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ABSTRACT

This document presents witnesses' testimonies from a Congressional hearing called to examine the health care access problems of the large number of Americans without health insurance and those suffering from underinsurance or inadequate coverage of primary acute or long-term care. Opening statements are included from Representatives Edward Roybal, Matthew Rinaldo, Ralph Regula, Don Bonker, Marilyn Lloyd, Olympia Snowe, and Helen Bentley. The text of the "USHealth" Program Act: An American Healthplan (H.R. 5070), Representative Roybal's bill to contain health care costs, maintain quality, and ensure access for all Americans is included. Witnesses providing testimony include: (1) a mother of a brain-injured child; (2) Albert Sabin, developer of the Sabin polio vaccine; (3) Mary Hatwood Futrell, president, National Education Association; (4) Arthur Flemming, chair, Citizens' Commission on Civil Rights; (5) Robert Helms, Assistant Secretary for Planning and Evaluation, Department of Health and Human Services; and (6) Uwe Reinhardt, professor of political economy, Princeton University. Prepared statements are included from Douglas Fraser, chairman, Health Security Action Council; Barbara Rohan, president, Re-Hab Associates, Inc. & Sports Medicine Center; Joyce Romero, secretary, Kansas Department on Aging; and Cancer Care, Inc. (NB)

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THE CATASTROPHE OF UNINSURED AND UNDERINSURED AMERICANS: IN SEARCH OF A U.S. HEALTH PLAN

HEARING

BEFORE THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

SEPTEMBER 12, 1986

Comm. Pub. No. 99-602

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THE CATASTROPHE OF UNINSURED AND UNDERINSURED AMERICANS: IN SEARCH OF A U.S. HEALTH PLAN

FRIDAY, SEPTEMBER 12, 1986

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 10:05 a.m., in room 2318, Rayburn House Office Building, Hon. Edward R. Roybal (chairman of the committee) presiding.

Members present: Representatives Roybal, Bonker, Vento, Regula, Jeffords, Bentley, and Meyers.

Staff present: Fernando Torres-Gil, staff director; Judith Lee, executive assistant; Gary Christopherson, director of health legislation; Nancy Smith, professional staff member; Christinia Mendoza, professional staff member; Austin Hogan, director of communications; Carolyn Griffith, staff assistant; Mary Wunderlich, communications assistant; Donna Carroll, intern; Eric Anderson, intern; and Joe Fredericks, deputy minority staff director.

OPENING STATEMENT OF CHAIRMAN EDWARD R. ROYBAL

The CHAIRMAN. The committee will come to order.

Most Americans would agree that the United States has among the best health care in the world, but only for those who have financial access to it—in other words, who have a lot of money. Then you can be sure that your health will be protected.

Today's hearing, however, will focus on two critical access problems. First is the large number of Americans without health insurance. Studies indicate that over 31 million people are uninsured. Without insurance protection, health providers are growing more reluctant to provide needed care.

The second access problem is underinsurance, inadequate coverage of primary acute or long-term care. Young families are more likely to be working for employers providing only minimal coverage. Over 200 million Americans lack long-term care protection, public or private, and risk financial disaster if hit by a catastrophic illness.

I am deeply saddened by the personal tragedies I have witnessed due to lack of access to health care. It is unacceptable that the personal catastrophe of an illness can be accompanied by a second catastrophe, a financial disaster striking young and old alike. Clearly a broad-based problem exists, and only a broad-based solution will provide protection which Americans so desperately need.

For that reason I have introduced H.R. 5070, the U.S. Health Act, a comprehensive health care plan guaranteeing access to the full spectrum of necessary health care. U.S. health will dismantle existing barriers to health care, slow the current health care cost spiral, and improve health care quality as well.

Given the forces of change and the current unequal access, now is the time to commit to protecting the uninsured and the underinsured. However, policymakers will not solve the problem unless and until Americans of all ages demand that it be done. When public policymakers believe that elections will be won or lost on this issue, this catastrophic problem of 31 million uninsured and 200 million underinsured Americans will be solved.

Today the Aging Committee will examine the problems of America's uninsured and underinsured and launch its search for a U.S. health plan to solve this tragic problem.

[The prepared statement, with attachments, of Chairman Roybal follows:]

PREPARED STATEMENT OF CHAIRMAN EDWARD R. ROYBAL

Most Americans would agree that the United States has among the best -- if not the best -- health care in the world. That is, the best health care for those who are fortunate enough to have access to it. Tragically, many Americans do not have adequate access to quality health care.

Today's hearing focuses on two critical access deficiencies. First is the large and growing number of Americans without any health insurance coverage. Recent studies indicate that over 31 million people are uninsured. Without the protection of insurance coverage, hospitals and other health care providers are growing more and more reluctant to provide needed care.

The second great deficiency is one of underinsurance, inadequate coverage for primary, acute, and long term care. Young families are more and more likely to be working for employers who provide only minimal coverage. Over 200 million Americans are without long term care protection -- be it public or private -- and are at major risk of financial disaster when hit by a catastrophic, chronic illness.

I am deeply saddened by the personal tragedies I have witnessed due to a lack of access to needed health care. It is unacceptable that the personal catastrophe of an illness can be accompanied by a second catastrophe -- a financial disaster striking young and old alike.

Clearly, a broad-based problem exists and only a broad-based solution will provide the full health protection which Americans so desperately require. Fortunately, there is no shortage of options for dealing with this tragic problem.

In choosing among the many available options or in packaging a more comprehensive solution, certain criteria should be applied:

- Are the uninsured fully insured?
- Are the underinsured insured for basic health costs?
- Are the underinsured insured for catastrophic acute care costs?
- Are the underinsured insured for catastrophic long term care costs?
- Is the quality of health care assured?
- Are costs affordable for individuals, government and employers?

By applying these criteria to all proposals, the American people and policymakers can judge the adequacy and merits of each one.

As we consider different options, it is important to keep in mind that all funding comes from the same source, the American people. How much Americans pay depends heavily on their health status and insurance coverage and, unfortunately, much less on their ability to pay. The challenge is to create an insurance system which ensures equal access even for those Americans with limited ability to pay for needed health care.

For that reason, I introduced my **USHealth** Act of 1986 (H.R.5070), a comprehensive, national health plan to guarantee that all Americans have access to the full spectrum of necessary health care. Not only would **USHealth** dismantle existing barriers to health care, but it would slow the current health care cost spiral and improve health care quality as well.

Uncertainty may exist about the extent of public support for active government leadership. However, the public, fostered by the growing personal experience with inadequate health care coverage, is making increasing demands that goverment address this crisis.

The federal government, in conjunction with States and the private sector, has the responsibility and must make the commitment to act as the steward of the nation's health care delivery system and the protector of the nation's health.

As has been demonstrated by the Medicare program, government can take an active role in ensuring access to millions of Americans while working closely with the private sector. Outside of the United States, Canada has also demonstrated that government can take the leadership role in assuring health care accessibility and affordability. So too the American government can take the lead in and should shoulder the responsibility for ensuring equity of access for all Americans. Equal access is far too important a matter to be left to chance, to whim or to "market forces."

Given the forces of change and the current inequities of access, now is the time to make the commitment to protect the uninsured and underinsured. The risk to the uninsured and underinsured is great and grows every day. High and rapidly rising health costs are hitting Americans of all ages. If costs are not controlled, health costs for everyone -- individuals, employers, government -- will outdistance our ability to pay for needed health care. We no longer can afford not to act.

However, public and private sector policymakers will not solve the problem unless and until Americans of all ages demand that it be done. When public policymakers believe that elections will be won or lost on this issue, then and only then will this catastrophic problem of over 31 million uninsured and over 200 million underinsured Americans be solved.

As a young Congressman in the 1960s, I was deeply heartened when two major federal initiatives, Medicare and Medicaid, were enacted to improve access to health care. And while these two programs have done much to help America's elderly and poor over the past twenty years, much more remains to be accomplished. On this, the twentieth and bittersweet anniversary of the beginning of Medicare and Medicaid, Americans must rededicate themselves to the principle of equal access to quality and affordable health care for all Americans, regardless of age or income.

Today the Aging Committee will examine the problem of America's uninsured and underinsured and launch its search for a U.S. health plan to solve this tragic problem.

USHealth An American Healthplan

Edward R. Roybal
Chairman, House Select Committee on Aging

The "USHealth Program Act" (H.R. 5070), introduced by Representative Edward R. Roybal in 1986, is designed to control health care costs for all Americans whether they be individuals, employers or government; to maintain health care quality for all providers and patients, and to ensure financial access to health care and prevent financial disaster resulting from catastrophic illness.

Cost Containment. The health care cost containment program covers all services and patients. In the short term, the cost containment provisions include paying all health care providers prospectively where payments are developed in consultation with providers. Future increases are limited to increases in the per capita GNP. States may set up alternative payment programs. In the long term, a major vehicle for containing costs is through HMOs.

Cost sharing of 20% for health and skilled long term care and 25% for non-skilled long term care is required, but only up to the catastrophic limits described below. Cost sharing is optional for those enrolled in qualified HMOs. The poor (under 100% poverty) and those spending down into poverty are exempt from any cost sharing which prevents access to needed care.

Cost. Target cost for USHealth is approximately 12 percent of GNP for the next 25 years.

Access. Financial access is ensured by making every citizen and resident eligible for "USHealth."

Benefits. Beneficiaries are protected from the cost of catastrophic illness. Their financial risk is limited to paying coinsurance as follows: a. up to a maximum $500/person/year, pays 20% of health care and skilled nursing home and home health costs, and b. up to a maximum $1,000/person/year, pays 25% of non-skilled long term care costs. Both "maximums" are indexed to per capita growth in GNP.

Basic health benefits (similar to Medicaid "categorically needy" package) include: inpatient and outpatient hospital services, physician services, rural health clinic services, laboratory, x-ray services, EPSDT (for those under age 21), family planning (individuals of child-bearing age), preventive care, prescription drugs, physical therapy, occupational therapy, medical equipment, prosthetic devices, orthopedic shoes, nursing home services, home health services, respite care, outpatient mental health care, inpatient psychiatric hospital services, basic dental care, vision care and other medical or remedial care recognized under State law and specified by USHealth.

Quality. The current federal quality assurance system consisting of Peer Review Organizations (PRO) is upgraded to place at least as much emphasis on quality assurance as on cost containment, cover all health care providers and consumers, cover all medical services (hospital, physician, nursing home, home health), set up a national Council on Quality Assurance, and add Consumer Advisory Boards to PROs. States have the option to develop their own qualified quality assurance system. Quality assurance is also addressed by federal qualification of HMOs.

Administration. The program is entitled "USHealth" and managed by the USHealth Administration (currently, Health Care Financing Administration) which is independent and off-budget. Most bill processing and review will be provided through contracts with private insurance companies.

Financing. Health care cost increases will closely match increases in per capita GNP -- approximating the Nation's ability to pay. The provisions to ensure financial access for all Americans are financed as follows: the savings generated by indexed prospective payment and capitation, beneficiary cost-sharing, an expanded cigarette tax, extension of the Medicare payroll tax to all incomes, a premium paid by the elderly (approximating the "Part B premium"), an employer tax based on compensation, State revenues covering 1/2 the cost of the poor, and a surcharge on corporate and individual income

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For further information on USHealth, contact the House Select Committee on Aging at 202-226-3375.

USHealth An American Healthplan

EDWARD R. ROYBAL
Chairman, House Select Committee on Aging

THE "USHEALTH" PROGRAM ACT: AN AMERICAN HEALTHPLAN (H.R. 5070)

A Bill to Contain Health Care Costs,
Maintain Quality and Ensure Access for All Americans

PURPOSE

This bill, introduced by Representative Edward R. Roybal in 1986, is designed to control health care costs for all Americans whether they be individuals, employers, or the government; to maintain health care quality for all providers and patients, and to ensure financial access to health care and prevent financial disaster resulting from catastrophic illnesses.

BACKGROUND

Between 1978 and 1984, health care costs rose at an average rate of 12.6 percent, or 3.4 percent faster than the Gross National Product. Health care costs continue to rise and are likely to reach a level of 11.2 percent of GNP by 1992 and over 12 percent by the year 2000. At the same time, the elderly are paying more and more of their limited incomes for health care even with the help of Medicare and Medicaid. Out-of-packets costs are estimated to be 18.5 percent of the elderly's income by 1991 -- substantially more than when the Medicare and Medicaid programs began. On top of the elderly's growing financial burden and in spite of the enactment of Medicare and Medicaid, many poor and near poor (over 30 million) still face major access problems due to lack of insurance. Many more Americans are underinsured against catastraphic illness.

BILL OVERVIEW

The provisions of this bill establish the USHealth program in 1992 which is designed to contain costs while maintaining quality and ensuring access. Health care cost increases will more closely match the increase in per capita Gross National Product -- a level which closely approximates the Nation's ability to pay. The provisions to ensure financial access for all Americans, including the poor, the unemployed, the uninsured, and the elderly are financed through the savings generated by the cost containment provisions, extension of the Medicare payroll tax to all incomes, beneficiary cost-sharing, an employer tax, an expanded cigarette tax, State revenues, a premium paid by the elderly approximating the "Medicare Part B premium", and a surcharge on carporate and individual income taxes. The provisions to maintain quality include the active involvement of providers and consumers, Peer Review Organizations or qualified state quality assurance programs, a national Council on Quality Assurance, and the qualification of Health Maintenance Organizations.

THE "USHEALTH" PROGRAM ACT -- BILL DESCRIPTION

In attempt to deal with the problems facing the American health care system, a series of changes are proposed. The provisions of this bill, if enacted, establish the USHealth program which contains health care costs for the federal government, States, employers, and consumers; improves financial access to needed services; helps maintain quality; and increases equity among health care providers and payers.

SECTION I: COST CONTAINMENT

This bill incorporates a series of cost containment measures. Greater incentives are provided for Health Maintenance Organizations. States are encouraged to implement state-wide cost containments programs as long as they perform as well as the federal program.

Health Maintenance Organizations

Medical care costs are contained through greater incentives for Health Maintenance Organization (HMO) development in general. The payment for HMOs is raised from the 95 percent of the Average Area Per Capita rate (AAPC) to 10[illegible] percent of AAPC as of 1992. The

federal government initiates a national campaign to encourage beneficiaries to enroll in qualified HMOs. Employers are encouraged to encourage their employees to enroll in HMOs.

Federal and State Cost Containment Programs

The federal health care cost containment program includes all services and patients. The cost containment provisions take effect in 1992 and include the following:

- Inpatient hospital care is paid on the basis of Medicare's prospective payment system using the Diagnostic Related Groupings and adjusted for population differences (for example, based on a severity index). Future payment increases are limited to increases in per capita Gross National Product.*
- Physician, nursing home, home health, hospice, and ancillary services (including prescription drugs) are paid on the basis of a prospectively set, fixed fee developed in consultation with health care providers and adjusted for differences in patient population, service type, and input prices. Future payment increases are limited to increases in per capita Gross National Product.
- Exceptions to this payment system include payments to qualified Health Maintenance Organizations and payments in States with an approved state-sponsored cost containment program. Future payment increases for Health Maintenance Organizations and state-sponsored cost containment programs are also limited in effect to increases in per capita Gross National Product.
- Payments to all providers are to be adjusted as necessary to ensure reasonable availability of health care services in rural areas, central city areas and for other "special need" areas or populations.
- Utilization review of all health and long term care services is conducted by the Peer Review Organizations.

States have the option to be exempt from the federal system and to implement their own alternative payment programs. In order to qualify for the exemption, the state program must meet or exceed the cost containment targets entailed in this bill and maintain access and quality equal to or exceeding the levels resulting from this bill. The alternative payment system must be mandatory for and equitably treat all types of providers covered under the State system.

For each State wishing to develop acceptable alternative payment programs, the federal government provides a three year development grant totaling between $1 million and $3 million. Those States with acceptable programs are eligible to have up to 50 percent of the savings (as compared to what would have paid under this amended law) added to reduce the state payment for the poor beginning in 1992. No additional state funds are needed to match this latter allocation.

Catastrophic Protection and Beneficiary Cost Sharing.

Beneficiaries are protected from the cost of catastrophic illness but are required to pay coinsurance as follows:

a. 20 percent of health care and skilled nursing home and home health costs up to a maximum of $500 per person per year (indexed to per capita GNP), and
b. 25 percent of non-skilled long term costs up to a maximum of $1,000 per person per year (indexed to per capita GNP).

Coinsurance payments are made directly to the Trust Fund. The above coinsurance provision is waived for individuals in families with incomes under the poverty level and for individuals whose health care costs require the family to spend down below the poverty level. However, a small copayment may be charged to the poor as long as it does not prevent access to needed health care.

SECTION II: INSURANCE SYSTEM

A. USHEALTH PROGRAM:

The following reforms take effect in 1992.

Administration

Overall administration is by the federal government's USHealth Administration (currently, the Health Care Financing Administration) which is both an off-budget and operates as an independent agency.

USHealth is overseen by the USHealth Board. The Health Board has responsibility for and control over the program subject to the law, or subsequent changes in the law, establishing the USHealth program. The Administrator of the USHealth Administration reports to the USHealth Health Board. Within the USHealth Administration, an Ombudsman office is established to represent beneficiary interests and help resolve beneficiary problems. The Administrator and the Health Board members are appointed by the President with the consent of the Senate.

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* Index is based on a 3-year moving average of increases in per capita Gross National Product.

Eligibility:
All U.S. citizens and residents are eligible for the USHealth program.

Financing:
Financing comes from several sources as outlined in Section V, "Financing of USHealth."

Benefits:
Beginning in 1992, the basic health benefits package, for all enrollees, are similar to Medicaid "categorically needy" package and include the following: inpatient hospital services, outpatient hospital services, physician services, rural health clinic services, laboratory, x-ray services, EPSDT (for those under age 21), family planning (individuals of child-bearing age), preventive care, prescription drugs, physical therapy, occupational therapy, prosthetic devices, orthopedic shoes, nursing home services, home health services, respite care, inpatient psychiatric hospital services, outpatient rehabilitation, hospice, alcohol and drug abuse rehabilitation, outpatient mental health, and other medical or remedial care recognized under State law and specified by the USHealth program. Dental (including dentures) and eyeglasses are added before the year 2000 unless total USHealth expenditures would exceed 12 percent of GNP.

More specifically, long term care benefits are covered. Full coverage is provided with the co-payments made to the Trust Fund. The co-payment is waived for low income and for spend-down individuals. As part of the long term care benefit package, incentives are to be developed to encourage families to keep a LTC family member in their home.

Beneficiaries are protected from the cost of catastrophic illness but are required to pay coinsurance as follows:

a. up to a maximum of $500 per person per year (indexed to per capita GNP) for health care and skilled nursing home and home health costs, and
b. up to a maximum of $1,000 per person per year (indexed to per capita GNP) for non-skilled long term care costs.

Payment:
Beginning in 1992, inpatient hospital care is paid on the basis of Medicare's prospective payment system using the Diagnostic Related Groupings and adjusted for population differences (for example, based on a severity index). Future hospital prospective payment rate increases are limited to increases in per capita Gross National Product as described in the cost containment section above. Capital is no longer allowed as a pass through and is added to the DRG payment. The adjustment to a particular DRG payment reflects the amount of capital required for that DRG. The mean ratio of total capital outlays to total non-capital DRG payments is not to exceed the mean ratio for the most recent three years.

Beginning in 1992, a fixed, prospective fee schedule is used to pay all providers in full for all non-hospital services (including physician, nursing home, home health, drugs, laboratory). The fee schedule is developed by the USHealth Administration in consultation with the respective provider organizations and consumer groups. In designing the fee schedule, adjustments should be made for differences in resource inputs and input prices. For example, physician payments should address current inequities among geographic areas, physician specialties, and types of service. To the extent possible and appropriate, the fee schedule should reward higher quality providers. For comparison purposes, the mean weighted fee cannot exceed the mean fee for a similar service paid under the current Medicare system as amended by this Act. Except for adjustments to reflect service delivery changes, future fee increases are limited to no more than increases in per capita Gross National Product.

Beginning in 1992, the payment for HMOs is raised from 95 percent of the Average Area Per Capita rate (AAPC) to 100 percent of AAPC. The AAPC is adjusted by age, sex, enrollee type, and appropriate health status factors. (The federal government initiates a national campaign to encourage beneficiaries to enroll in qualified HMOs.)

Beginning in 1992, the approved health care provider fee is full payment.

Medical education is paid on the same basis as under current Medicare law.

This provision does not apply in States with federally qualified alternative payment programs.

Delivery System:
HMOs are the preferred providers of health care for beneficiaries. The USHealth Administration shall require require participating HMOs (including HMOs, CMPs, and IPAs) to be qualified as specified under Title XIII of the Public Health Service Act beginning in 1992. HMOs must continue to be qualified on an annual basis. HMOs shall be penalized or removed from the program when they no longer meet the HMO qualification standards. The Office of Health Maintenance Organization's cost for carrying out the ongoing qualification process is covered by the Trust Fund.

Beneficiary Information:
Publications are provided which give side-by-side comparisons of HMOs in each area of the country. The use of HMOs is promoted, including the provision of a comparison of HMOs with the non-HMO providers in terms of quality assurance, covered services, and out-of-pocket costs to the elderly and disabled. (Information on the quality assurance system and the availability of a consumer hot-line are described in the quality assurance section.)

B. MEDICARE AND MEDICAID:

USHealth replaces the current Medicare and Medicaid programs and is built upon those two programs. All Medicare and Medicaid beneficiaries are entitled to enroll in USHealth.

C. PRIVATE INSURANCE:

The only private insurance which remains would be for benefits beyond those provided in USHealth. Any costs would not qualify for a tax deduction either for employers or for individuals.

Insurance companies are permitted and encouraged to perform intermediary and carrier functions under contract to the USHealth Trust Fund.

SECTION III: DELIVERY SYSTEM

As described above, Health Maintenance Organizations (HMOs) and similar delivery systems are to become the primary vehicle for delivering health and continuing care services in the long term. This is not to limit future delivery systems to the current definition of HMOs as long as alternative delivery systems are initially and continuously qualified by the USHealth Administration, provide the full range of benefits, and perform as effectively in terms of quality, access, cost to the consumer, cost to the respective third party payer, and covered services.

Campaign to Promote HMOs

The federal government is to conduct a national media campaign to encourage the development of and enrollment in HMOs.

Financial Incentives for HMOs

This bill improves the HMOs' financial position relative to other delivery approaches by raising the payment rate to 100 percent of the Average Area Per Capita rate by 1992.

SECTION IV: QUALITY ASSURANCE SYSTEM:

The current Medicare quality assurance (QA) system of Peer Review Organizations) is upgraded to cover all medical services (inpatient and outpatient) for all patients and all providers and to place as much emphasis on quality assurance as on cost containment. Most provisions are to be phased in as of January 1, 1991. A State has the option to obtain a waiver from this requirement if it establishes its own plan of quality assurance and as long as it provides at least the same level of protection as the amended federal plan.

Increased Emphasis on Quality Assurance:

This bill requires DHHS and, subsequently, the USHealth Administration to award, administer, and evaluate its PRO contracts under the stipulation that at least one-half of the PROs' level of effort is for the purpose of quality assurance as of January 1, 1991.

Extension to All Patients and Payers:

This bill requires the DHHS and, subsequently, the USHealth Administration and its contract PROs to conduct quality assurance for all patients.

Extension to All Medical Services:

This bill requires the DHHS, and, subsequently, the USHealth Administration and its contract PROs to conduct quality assurance activities on all medical providers including hospitals, physician offices, nursing homes, home health agencies, and hospices. The level of PRO effort expended on each type of provider is in proportion to the national health care expenditures for this type of provider. Similarly, membership on PRO boards reflects the range of health care providers reviewed by the PRO.

Hospital Discharge Planning:

This bill sets guidelines for discharge planning to protect against inappropriate discharges and to ensure a smooth and timely transition to post-hospital care. It also requires that hospitals have in place a discharge planning process that begins as close to the time of hospital admission as appropriate and that alerts nursing home and home health providers of a patient's anticipated need for post-hospital care at the earliest possible time.

Quality Assurance "Hot-line":

This bill requires PROs to have a 7-day-a-week hot-line for receiving questions and complaints from health care providers, consumers, and interested parties concerning health care quality problems. PROs are required to assist in the resolution of any legitimate quality related problems. The USHealth Administration, in coordination with each PRO, shall provide beneficiaries with the hot-line number for their PRO in a way that can be easily attached to their USHealth cards.

Local Consumer Advisory Board:

This bill requires each PRO to have a Consumer Advisory Board (CAB) by October 1, 1986 which conducts ongoing oversight of the PROs, provides input into the award and evaluation of PRO contracts, and can receive input from Medicare beneficiaries and other interested parties. The CAB and the PRO are responsible for educating consumers on quality assurance and on the availability of assistance from the PRO and other agencies. The PRO makes available to the CAB such information and staff as are necessary to carry out the CAB function, but not review information on either individual health care providers or consumers.

The CAB is required to prepare an annual report on the PRO's performance and submit that report to the respective Governor(s), to the national Council on Quality Assurance, and to DHHS and, subsequently, the USHealth Administration. CAB input is to be utilized in decisions to award PRO contracts.

The CAB consists of 5-7 volunteer members appointed by the respective Governor of the State covered by the PRO and representing organizations of the elderly, the disabled, the poor and other consumers.

National Council on Quality Assurance:

This bill requires the establishment of a national Council on Quality Assurance (CQA). The Council's function is to provide oversight on the operations of the quality assurance system and make recommendations to DHHS and, subsequently, the USHealth Administration, and to the Congress for its improvement. Its oversight function includes the review of the administration of quality assurance, the overall performance of the PROs and waivered state plans, reports of the Consumer Advisory Boards, quality assurance studies and methodologies developed by DHHS, the USHealth Administration and others, the data needs of the PROs and input from interested parties.

DHHS and, subsequently, the USHealth Administration are required to provide such information as is needed by CQA to carry out its responsibilities. Based upon these reviews, the Council is to make recommendations annually for improving quality assurance to DHHS and, subsequently, the USHealth Administration, and to the Congress. DHHS and, subsequently, the USHealth Administration are required to take into account CQA input in its administration of the PRO program.

The Congressional Office of Technology Assessment (OTA) will provide for the appointment of the fifteen member Council consisting of equal numbers of health care providers, health care consumers, and experts in quality assurance. Subject to the review by OTA, the Council may employ staff as necessary to carry out these functions.

Studies and Reports:

The USHealth Administration shall prepare an annual report which assesses the performance of the quality assurance system and addresses the recommendations of the CQA and the concerns and recommendations of the CABs. DHHS and, subsequently, the USHealth Administration shall analyze the impact which the federal cost containment system, limitations on health care provider payments, and Health Maintenance Organizations have had on health care quality, access and beneficiary cost and submit an annual report to Congress. The USHealth Administration shall conduct studies on and develop improved methodologies for quality assessment and assurance for health care services including hospital, physician, nursing home, home health services, and hospice services. The USHealth Administration shall submit an annual report to Congress on the progress toward developing such methodologies.

Financing:

As compared to current law and adjusted for inflation, the funding level for the PRO program is increased by 50 percent in FY 1992 (first year of implementation), by 65 percent in FY 1993, and by 75 percent in FY 1994 and in subsequent years. The funding for the CQA and the PROs program will be made from the Trust Fund. For those States with their own federally qualified quality assurance plans, the USHealth Administration is authorized to make available funds up to the amount that would have gone to the respective PRO as authorized above.

SECTION V: FINANCING OF THE USHEALTH PROGRAM

Much of the long term cost of expanding access and reducing costs for all beneficiaries comes from reducing health care cost inflation for all payers and all health care providers.

- Health care cost savings are expanded by holding cost increases down to per capita growth in GNP.
- Beneficiary cost-sharing applies to all services (but is limited by the catastrophic provisions).

In order to finance the USHealth program and to provide an orderly transition from the current system of financing health care, USHealth is financed through the following revenue sources:

- A premium approximating the cost of the "Medicare Part B premium payment" is charged to people over the age of 65. This premium may be waived for elderly with incomes under the poverty level.
- Employers pay a tax based on a percentage of employee compensation. The basis for setting that percentage is the aggregate amount which employers are paying under the current system for employee and retiree health benefits in 1990.
- The cigarette excise tax is raised by 16¢ and indexed to per capita GNP.
  The "Medicare payroll tax" is expanded to cover all income levels.
  States provide revenues equal on average to 1/2 cost of the poor (i.e., everyone under poverty level). Payment formula is as follows: (total cost of poor) X 1/2 X (State population / US population) X (State per capita income / National per capita income).
- An earmarked surcharge on all corporate and personal income taxes is made which equals the amount necessary to maintain the solvency of the USHealth Trust Fund. (Financing formula: Total USHealth expenditures minus cost cost sharing minus cost savings minus State share minus cigarette add-on minus the "Medicare payroll tax" minus the employer tax minus other revenue additions = Net revenue required from an X% surcharge on federal corporate and individual income tax.)
- Revenues are placed in the USHealth Trust Fund which is off-budget.
- Within 6 years, the Trust Fund should have an appropriate reserve for contingencies.

For more information on the "USHealth" Program Act, contact the House Select Committee on Aging (202-226-3375), Room 712, Annex 1, Washington, D.C. 20515.

AMERICA'S UNINSURED AND UNDERINSURED:

A NATION AT RISK OF INADEQUATE HEALTH CARE AND CATASTROPHIC COSTS

EXECUTIVE SUMMARY

Health insurance coverage for 235 million Americans of all ages is a deep and immediate concern to Congress because it is an essential element if people are to access needed health care and reduce the personal burden of catastrophic health costs. Every day, personal tragedies are hitting not only millions of individuals with catastrophic illnesses but their families as well.

The Uninsured and Underinsured. Studies continue to document serious gaps in health insurance coverage. Over 31 million persons -- over 13 percent of Americans -- are **uninsured.** Of equal concern are the many millions who are **underinsured** -- those whose existing insurance coverage is inadequate. The underinsured are also not assured of access to needed health care, be it primary, acute or long term care, nor are they protected from catastrophic health costs. Over 85 percent of Americans are underinsured against catastrophic health costs.

The Uninsured and Underinsured at Risk. For the uninsured and underinsured, the risk is great and growing. One million families have at least one family member who was refused care because of inadequate funds. Up to 10 percent of families face health costs in excess of 10 percent of income. When facing a catastrophic acute or long term illness, over 200 million Americans are underinsured. Sadly, the risk is growing. As one example, the elderly, on the average, face paying as much as 18.5 percent of their income for health care by 1991 -- significantly higher than the 12.3 percent paid in 1977.

Options for Insuring the Uninsured and Underinsured. Fortunately, there is no shortage of options for insuring the uninsured and underinsured. For those who argue that **private sector options** should be the primary or only options used, they cite approaches such as having employers extend and expand coverage, instituting medical IRAs or health savings accounts, allowing expanded tax deductions or credits, or encouraging insurance companies to make catastrophic insurance policies available. What must be kept in mind is that these private sector options serve to decrease federal revenues and do not directly address the problems of the medically indigent and others with limited ability to pay.

For those arguing that **public sector** options should be the primary or only options used, alternative approaches include extending the Medicaid program, purchasing private insurance, allowing low income individuals to "buy" into Medicaid, developing private "risk pools" where individuals could buy insurance at group rates, creating "bad debt and charity pools" for hospitals, and using grant programs such as the community health center and maternal and child health programs. At the federal level, public options include extending the eligible Medicare population or expanding coverage to include catastrophic acute and long term care, instituting voucher-type systems, or providing services directly as in the Veterans Administration and the Indian Health Service.

A more ambitious and comprehensive federal public insurance option might protect all Americans (including the fully insured, the uninsured, and the underinsured), cover health and long term care, shield Americans from catastrophic acute and long term care expenses, upgrade the quality assurance system and contain total health care costs. One such comprehensive health protection package is the Chairman's proposed "USHealth" program.

Criteria for Assessing the Options. As we consider the available options, it is important to keep in mind that all funding comes from the same source, the American people. How much Americans pay depends heavily on their health status and insurance coverage and, unfortunately, much less on their ability to pay. The challenge is to create a system of insurance which ensures equal access even for those Americans with limited ability to pay for needed health care.

In choosing among the options for ensuring equal access for all Americans or in packaging a more comprehensive solution, certain criteria should be applied:

- Are the uninsured fully insured?
- Are the underinsured insured for basic health costs?
- Are the underinsured insured for catastrophic acute care costs?
- Are the underinsured insured for catastrophic long term care costs?
- Is the quality of health care assured?
- Are costs affordable for individuals, government and employers?

By applying theses criteria, the American people and policymakers can judge the adequacy and merits of each health insurance proposal offered.

Commitment to Insuring the Uninsured and Underinsured. Uncertainty may exist about the extent of public support for active government leadership. However, the public, fostered by the growing personal experience with inadequate health care coverage, is making increasing demands that government address this crisis.

The federal government, in conjunction with States and the private sector, has the responsibility and must make the commitment to act as the steward of the nation's health care delivery system and the protector of the nation's health. Government should shoulder the responsibility and can take the lead in ensuring equal access. "Equal access" is far too important a matter to be left to chance or to whim or to "market forces."

Now is the time to make the commitment to protect the uninsured and underinsured. The risk to the uninsured and underinsured is great and grows every day. High and rapidly rising health costs are hitting Americans of all ages, incomes and types of illness. If costs are not controlled, health costs for everyone -- individuals, employers, government -- will outdistance our ability to pay. We no longer can afford not to act.

However, public and private sector policymakers will not solve the problem unless and until Americans of all ages demand that it be done. When public policymakers believe that elections will be won or lost on this issue, then and only then will this catastrophic problem of over 31 million uninsured and over 200 million underinsured Americans be solved.

AMERICA'S UNINSURED AND UNDERINSURED: A NATION AT RISK OF INADEQUATE HEALTH CARE AND CATASTROPHIC COSTS

Health insurance coverage for 235 million Americans of all ages is a deep and immediate concern to Congress because it is an essential element if people are to access needed care and reduce the personal burden of catastrophic health costs. * Recent studies continue to document serious gaps in insurance coverage. **Over 31 million persons -- more than 13 percent of the U.S. population -- are uninsured, highlighting the need for some type of remedial action. Of equal concern are the many millions of Americans who are underinsured -- those whose insurance is inadequate.** The underinsured are also not ensured access to needed health care, be it primary, acute or long term care, nor are they protected from catastrophic health costs. **When faced with a catastrophic acute or long term illness, over 200 million Americans are potentially underinsured.**

THE UNINSURED

Any effort to estimate the number of uninsured people is difficult due to the lack of a satisfactory data gathering system. As a result, the following current estimates of the uninsured are low since they miss significant numbers of uninsured.

The U.S. Census Bureau's Survey of Income and Program Participation (SIPP) taken during the third quarter of 1985 revealed that **approximately 13.5 percent of Americans, representing 31.8 million persons, are without health insurance -- public or private.** The uninsured are, by and large, people under age 65, as the Medicare program provides coverage for the elderly. About 150,000 people over age 65 are uninsured. The 16 to 24 age group contains the largest proportion of uninsured with over 22 percent lacking insurance. Sixteen percent of those under the age of 16 are without insurance.

The SIPP survey shows that of those under 65 years of age, about 15.2 percent are uninsured. To give some historical perspective to this statistic, 12.5 percent of people under age 65 were uninsured in 1977. (National Medical Care Expenditure Survey (NMCES), 1977) This proportion rose to a high of 17.1 percent in 1983. (SIPP, 1983)

The Employment Factor. **Approximately 75 percent of the uninsured are employed adults or their dependents.** The employed uninsured tend to be young and relatively less educated. Workers in occupations that are seasonal or transitory in nature and those in occupations requiring relatively less technical skill are also more likely to be uninsured. (National Center for Health Services Research, 1985)

The Poverty Factor. Although the uninsured are distributed across income levels, a disproportionately large share are economically disadvantaged. According to the 1982 Current Population Survey, **35 percent of the uninsured have a family income below the federal poverty threshold of $9000 for a family of four; 64 percent (nearly two-thirds) of the uninsured have a family income below 200 percent of the federal poverty standard.**

The Geographic Factor. The likelihood of being without health insurance appears, to some extent, to be a function of geographic region of residence. **Two-tenths of the residents of the West South Central states are uninsured, whereas, only one in ten residents of New England are uninsured.** Some of this variation is directly related to the varying adequacy of state eligibility criteria of Medicaid programs. (Congressional Research Service, 1986)

The Medicaid Factor. Medicaid deserves much credit for improving the poor's access to health care. However, many poor persons are not eligible for Medicaid coverage. Poor people may not qualify for Medicaid either because they don't meet the categorical requirements (i.e. they aren't aged, blind, disabled, or eligible for Aid to Families with Dependent Children) or because they don't meet the state-determined resource and income requirements. This latter problem is exemplified by the fact that the cut-off income level for Medicaid eligibility dipped below 55 percent of the federal poverty threshold in 23 states in 1984. (Marion Lewin and Lawrence Lewin, Business and Health, September 1984)

According to a 1982 study, only 37.5 percent of those -- both aged and nonaged -- with incomes below the federal poverty standard are actually eligible for Medicaid. Another 13.2 percent of those with incomes below the federal cut-off level are covered by employer-provided health insurance, **leaving 49.3 percent of the federally-certified poor without any form of public or private health insurance.** (Thomas Joe, Judith Meltzer, and Peter Yu, Health Affairs, Spring 1985) These are the people who fall through Medicaid's cracks.

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* Access is defined as the ability to pay for services, the availability of services, and the absence of other barriers. This report focuses on the ability to pay issue.

The Uninsurable Factor. Included in the group of persons who are uninsured are persons who are not covered by a group health plan and cannot purchase private health insurance because of preexisting medical conditions. This group also includes many insured Americans who have very restricted coverage due to one or more serious health problems. President Reagan's Health Policy Advisory Group estimates that **"perhaps one million Americans are uninsurable .... totally or for specific conditions."**

THE UNDERINSURED

The many millions of Americans who have inadequate health insurance -- the **underinsured** -- are also a major public policy concern. Estimates of the underinsured are determined by examining the extent to which payments of out-of-pocket health costs affect a family's financial well-being. Even for those with some type of health care coverage, the associated out-of-pocket costs, as a result of premiums, deductibles, and copayments as well as payment for noncovered services, can reach catastrophic levels or preclude persons from seeking needed care.

A recent National Center for Health Services Research (NCHSR) study suggests that "two distinct types of families have out-of-pocket expenses that are relatively high in relation to income: (1) families which, due to high-cost illness, incur total health care bills so large that in spite of relatively good insurance coverage, the uncovered portion paid out-of-pocket amounts to a considerable sum; these are the intended beneficiaries of most traditional stop-loss catastrophic health insurance proposals; and (2) families for whom relatively small out-of-pocket expenses represent a high percentage of their income due to a combination of low income and inadequate health care coverage."

Depending on the way "underinsured" is defined, estimates of the proportion of the privately insured under age 65 who are inadequately insured range from 8 percent to 26 percent. **In general, about 13 percent are thought to be underinsured.** However, the percentage who are underinsured for catastrophic acute or long term illnesses is much higher -- **more than 85 percent of all Americans.** According to the NCHSR report, between one-third and two-thirds of all nongroup enrollees are underinsured. Group enrollees, who represent 90 percent of persons with private insurance, are still a substantial majority of the underinsured.

The Catastrophic Cost Factor On the problem of catastrophic health costs, the NCHSR study shows that the families with a high ratio of out-of-pocket expenses to income were found to be headed by someone under 18 or over 65 years of age, not employed, and with lower income. The proportion who are underinsured is highest when it comes to catastrophic protection -- insurance against the small possibility of large uninsured expenses from a costly illness. **More than 200 million Americans - over 85 percent of Americans - lack adequate protection against catastrophic acute or long term care costs.**

The High and Rising Cost Factor. Already individuals and employers are having difficulty paying the high cost of adequate health insurance. Even for people who might be able to afford adequate insurance and most other out-of-pocket health care costs, the future presents the problem of rapidly rising out-of-pocket costs. Elderly out-of-pocket costs are projected to rise about twice as fast as their income. Even working Americans are unlikely to keep pace. **Per capita health care costs are projected to grow at an 8.0 percent annual rate between 1985 and 1990 while the costs of other goods (Consumer Price Index) are projected to grow at a much slower annual rate of 4.8 percent.** (Health Care Financing Review, Spring 1986)

The Non-covered Acute Care Factor. Americans over the age of 65 are in a somewhat different position than Americans under the age of 65 primarily due to the availability of Medicare coverage for basic medical care. However, most elderly are still at risk, just as are the non-elderly. Medicare and most private insurance exclude payments for preventive examinations, eyeglasses, prescriptions, prosthetic devices, and foot care. Furthermore, both Medicare and most private insurance provide only the most minimal protection against catastrophic health care costs -- the most significant of which is the enormous, unpredictable, and growing cost of long term care.

One indicator of the inadequacy of Medicare coverage is the fact that about two-thirds of the elderly have chosen to purchase supplemental insurance policies. However, the supplemental insurance policies are both expensive and generally only help pay for deductibles and coinsurance for Medicare covered services. As a result, the elderly remain unprotected from the costs of dental care, prescription drugs, and long term care. Further, neither Medicare nor the private supplemental policies provide protection for expenses resulting from longer term, acute illness.

The Non-covered Long Term Care Factor. When it comes to long term care, over 85 percent of Americans are underinsured. Home care remains a relatively uncovered service for most Americans. Nursing home coverage provided by Blue Cross and Blue Shield, commercial insurance plans and Medicare is limited. Currently, only 16-25 private insurance companies offer long-term care insurance which is substantially more comprehensive than standard Medigap policies and which go beyond restrictive Medicare definitions for nursing care.

At a cost of $20,000 to $50,000 a year, nursing home care would be financially devastating to most people. According to a study conducted by Harvard and Massachusetts Blue Cross and Blue Shield for the Committee on Aging, **nearly two out of three elderly persons living alone will impoverish themselves after only 13 weeks in a nursing home.**

The Age 55 to 65 Factor. Inadequate private insurance is a problem particularly among those between the ages of 55 and 65. While this age group is more likely to be insured throughout the year than the rest of Americans, they face the likelihood of high medical expenditures at an age of reduced employment, reduced income and lower rates of group insurance enrollment. (NCHSR, 1985)

THE UNINSURED AND UNDERINSURED AT RISK

The risks and problems facing many millions of uninsured and underinsured Americans are great and growing.

THE RISK OF INADEQUATE ACCESS. According to a 1982 Robert Wood Johnson Foundation survey on access, one million families have at least one member who was refused care because of inadequate funds. Similarly, 5.1 percent of insured families found it difficult to obtain health care in the twelve months prior to the survey. The survey also indicated that 4.8 percent of insured families needed health care in the twelve months prior to the survey but did not obtain it. **A Louis Harris survey indicated that over 8 percent of American families in 1983 did not obtain needed medical care for financial reasons.**

The National Medical Care Expenditure Survey determined that utilization patterns suggest that the uninsured may not have the access they need to medical care. The insured under age 65 receive 56 percent more physician ambulatory care than the uninsured. Further, the insured under age 65 receive almost twice as much hospital care as the uninsured.

Not only do the uninsured receive less care, but they perceive themselves to be in poorer health than the insured. The Robert Wood Johnson Foundation's 1982 study shows that **20.4 percent of the uninsured believe themselves to be in fair or poor health compared to only 13.4 percent of the insured.** Poorer health status of the uninsured indicates that more health care is needed for the uninsured, not less.

THE RISK OF CATASTROPHIC HEALTH COSTS. Catastrophic costs refer to large, unaffordable, out-of-pocket health care expenditures that can result from illnesses requiring either acute or long term care. In determining whether or not a person's medical expenses are catastrophic, either a person's medical expenditures can be measured against a specific dollar threshold amount or measured relative to an individual's income.

A recent National Center for Health Services Research study documented the number of families with high out-of-pocket health care expenditures relative to income in 1977. **Of all families, 19.9 percent incur out-of-pocket costs for personal health services exceeding 5 percent of income; 9.6 percent have health care costs in excess of 10 percent of income; and 4.3 percent have health costs in excess of 20 percent of income.**

Another indicator of the inadequacy of coverage is the fact that elderly Americans will be spending just over 16 percent of their income on health care in 1986, averaging $1,850 per person. **Older persons now pay a larger portion of their income for health care than they did when Medicare and Medicaid began 20 years ago.** (House Select Committee on Aging, 1986)

Since the previous figures are based solely on out-of-pocket expenses actually paid, they likely underestimate the problem. These figures fail to incorporate costs for those services that were needed but were not sought by or provided to the uninsured and underinsured.

THE GROWING RISK FOR THE UNINSURED AND UNDERINSURED. The impact of non-existent or inadequate insurance on access to needed care is expected to grow even stronger as health care costs continue their upward spiral. As health care costs rise rapidly, it is less likely that Americans can pay the out-of-pocket costs and more likely that access is restricted.

Rising Costs. In the case of the elderly, the House Committee on Aging estimates that **out-of-pocket costs will grow from 12 percent of elderly income in 1977 to 18.5 percent in 1991.** By 1991, elderly out-of-pocket costs are projected to average $2633 per person and to amount to about 40 percent of total elderly health care costs. For the total population, the situation will also get worse as health expenditures continue to rise faster than the Gross National Product, a measure of the nation's ability to pay.

Changing Employer Behavior. Employers -- the primary purchasers of private health care coverage -- are increasingly becoming "prudent buyers" and are beginning to shop for the least expensive providers of health care and encourage insurance companies

to do the same. Responding to this pressure to reduce prices, health care providers are beginning to scrutinize their costs, eliminate or reduce services that do not generate an adequate level of revenues, and avoid free or discounted care for the poor and near poor.

Increasing Competition. Further exacerbating the already restricted financial access to health care is the current emphasis on "competition" in our health system. Prior to this era of "market reform" in health care, private and public health care providers provided varying amounts of free and discounted care and could recover the associated "lost" charges by shifting them onto the bills of private paying patients. But this voluntary and informal pattern of cross-subsidization of free and discounted care is becoming less available as the health system becomes more price-sensitive.

Changing Hospital Behavior. Vanderbilt University survey indicates that both private and public hospitals are taking actions to limit the amount of free care provided. In 1981 and 1982, **approximately 15 percent of hospitals adopted explicit policies and procedures to restrict care to nonpaying patients.** (Geraldine Dallek, Health/PAC Bulletin, May/June 1985)

The growing pressure to limit the amount of care provided to non-paying patients appears to be prompting a rise in the practice of "patient dumping." While data on the number of patients transferred due to an inability to pay do not exist, a study of Chicago's Cook County Hospital revealed that the number of annual transfer patients received by the hospital increased 500 percent between 1979 and 1985. (Washington Report on Medicine and Health, July 15, 1985) Similarly, a study of Parkland Memorial Hospital in Dallas, Texas indicated a 300 percent increase in the number of transfer patients received between 1983 and 1985. (Wall Street Journal, March 8, 1985)

According to the Urban Institute, even state and local governments have reduced their direct financial support for public hospitals -- what have long been considered the hospitals of last resort for the uninsured and underinsured. (Marion Lewin and Lawrence Lewin, Business and Health, September 1984) In 1985 alone, **17 state and local public hospitals closed their doors.** Furthermore, the need for subsidized care is most critical in impoverished communities where local taxpayers are less able to finance care for the uninsured poor. (Urban Institute, June 1984)

INSURING THE UNINSURED AND UNDERINSURED

"Equal access" occurs when entry into the health care delivery system is based on need rather than factors such as status of health insurance coverage, ability to pay out-of-packet costs, or place of residence. As described earlier, most Americans do not have equal access. However, most Americans would agree that the inequities should be removed and that equal access to health care should be achieved. The key questions are how and when.

OPTIONS FOR INSURING THE UNINSURED AND UNDERINSURED. Fortunately, there is no shortage of options for insuring the uninsured and underinsured. Though there are many ways to characterize the many options, much of the current debate focuses on private versus public sector options.

Private Sector Options. Some argue that private sector options should be the primary or only options used. Here the approaches might include encouraging or requiring employers to extend coverage to more employees, retirees or laid-off workers or to expand the breadth of coverage for all employees. Another option might be to encourage personal saving for medical expenses through vehicles such as medical IRAs or health savings accounts. Another route might be to allow expanded tax deductions or credits to cover expenses such as for long term care. Yet another option is to encourage insurance companies to make more insurance policies available which cover catastrophic acute and long term care expenses. What must be kept in mind is that these private sector options serve to decrease federal revenues and do not directly address the problems of the medically indigent and others with limited ability to pay.

Public Sector Options. Some argue that public sector options should be the primary or only options used. State and federal options might include extending the Medicaid program to pick up all of the poor or the unemployed. A different approach for the unemployed might be to purchase private insurance for them. Another Medicaid alternative might be to allow low income individuals to "buy" into Medicaid. A similar option might be for States to develop private "risk pools" where individuals could buy insurance at group rates. States might tax hospitals to create "bad debt and charity pools" and permit hospitals to draw from these pools to cover uncompensated care. Another route might be to use grant programs such as the community health center and maternal and child health programs.

Looking only at the federal level, a wide range of options are available. Using Medicare as a base, federal approaches might include extending the eligible Medicare population or expanding coverage to include catastrophic acute and long term care. Some recent proposals to institute Medicare vouchers might be used to cover other people. The federal government might also provide the services directly as it does through the Veterans Administration and the Indian Health Service. A hospital-based option might be to mandate some minimum "fair share of free care" and provide enforcement through conditions for hospital licensure, certificate of need approval, participation in the Medicare program or eligibility for tax-exempt bonds.

A more ambitious and comprehensive federal public insurance option might protect all Americans (including the fully insured, the uninsured, and the underinsured), cover health and long term care, shield Americans from catastrophic acute and long term care expenses, upgrade the quality assurance system and contain total health care costs. One such comprehensive health protection package is the "USHealth" plan introduced by Chairman Roybal. (See attached summary of USHealth Act of 1986 (H.R. 5070)).

CRITERIA FOR ASSESSING THE OPTIONS. As we consider the available options, it is important to keep in mind that **all funding comes from the same source, the American people.** Funding may come directly or indirectly from the American people through individual premiums, joint employer/employee paid premiums, individual and corporate taxes or direct out-of-pocket payments to health care providers. How much Americans pay depends heavily on their health status and insurance coverage and, unfortunately, much less on their ability to pay. **The challenge is to create an insurance system which ensures equal access even for those Americans with limited ability to pay for needed health care.**

Many options are available for ensuring equal access for all Americans. In choosing among them or in packaging a more comprehensive solution, certain criteria should be applied:

- Are the uninsured fully insured?
- Are the underinsured insured for basic health costs?
- Are the underinsured insured for catastrophic acute care costs?
- Are the underinsured insured for catastrophic long term care costs?
- Is the quality of health care assured?
- Are costs affordable for individuals, government and employers?

By applying these criteria to all proposals, the American people and policymakers can judge the adequacy and merits of each one.

COMMITMENT TO INSURING THE UNINSURED AND UNDERINSURED. Uncertainty may exist about the extent of public support for active government leadership. However, the public, fostered by the growing personal experience with inadequate health care coverage, is making increasing demands that goverment address this crisis.

The federal government, in conjunction with States and the private sector, has the responsibility and must make the commitment to act as the steward of the nation's health care delivery system and the protector of the nation's health.

As has been demonstrated by the Medicare program, government can take an active role in ensuring access to millions of Americans while working closely with the private sector. Medicare has continued to mature as a major health insurance program and continues to provide leadership on cost containment and quality assurance issues. Outside of the United States, Canada has also demonstrated that government can take the leadership role in assuring health care accessibility and affordability. So too the American government can take the lead in and should shoulder the responsibility for ensuring equal access for all Americans. **Equal access is far too important a matter to be left to chance, to whim or to "market forces."**

Major health care reforms as envisioned above are never easy, but they must be done. They can be done if we put aside our differences and recognize what is most important -- namely, protecting the American people.

Given the forces of change and the current inequities of access, now is the time to make the commitment to protect the uninsured and underinsured. The risk to the uninsured and underinsured is great and grows every day. High and rapidly rising health costs are hitting Americans of all ages. If costs are not controlled, health costs for everyone -- individuals, employers, government -- will outdistance our ability to pay for needed health care. **We no longer can afford not to act.**

Public and private sector policymakers will not solve the problem unless and until Americans of all ages demand that it be done. **When public policymakers believe that elections will be won or lost on this issue, then and only then will this catastrophic problem of over 31 million uninsured and over 200 million underinsured Americans be solved.**

The CHAIRMAN. The Chair would now recognize Mr. Regula.

Mr. REGULA. Thank you, Mr. Chairman.

First of all, I would like unanimous consent that our colleague, Mr. Rinaldo's, statement be made part of the record.

The CHAIRMAN. Without objection, so ordered.

[The prepared statement of Representative Rinaldo follows:]

PREPARED STATEMENT OF REPRESENTATIVE MATTHEW J. RINALDO

Thank you Mr. Chairman. Our nation's health care system has undergone revolutionary changes in organization and financing in the current decade. One of the consequences of this revolution is the subject we are discussing today: who will provide and pay for the health care of those who cannot afford to and are not insured?

I am proud to say that my state of New Jersey has been a winner in this revolution by taking the leading edge in providing quality health care for all its citizens. It has expanded the Medicaid program to include more of the medically needy, and has instituted and all-payer Diagnosis Related Group method of payment. By using an all-payer system, New Jersey is able to allocate the costs of bad debt and charity care proportionately to all insurers, and the burden of this care is shared more broadly and equitably.

I am also proud of the success of the Medicare system, which covers 30 million people. This success is demonstrated by the extensive coverage of the elderly today in contrast to the dramatic lack of insurance prior to 1966. Medicaid and private insurance fuirther help to fill the gaps in health insurance for the elderly.

One of the losers in the revolution on health care spending is the practice of cost-shifting. Cost-shifting subsidized the patients who could not pay for health care by charging those who could pay substantially more for the same services. The need for cost-effectiveness in the health care industry has forced the long-standing practice of cost-shifting out into the open, and brought about a more equitable payment system, which is a victory for the patients.

However, at the same time the age-old problem of the medically indigent was brought to the forefront.

There are several ways we can look at reforming and restructuring health insurance so that those who "fall between the cracks" are caught. Any long term solution must strengthen and not replace current financing and methods of providing health care.

In the private sector, we need to increase the incentives for creative and comprehensive health insurance to reduce the size of the medically indigent population. In the public sector we must restructure and extend public programs to finance care for those who are unable to obtain private insurance.

We must keep in mind two things as we set out to revolutionize our nation's health care system again. Better private insurance usage and options can result in more cost-effective usage of public welfare funds. Also, proper health care throughout a person's life will help their health later in life; without proper care, many risks are taken that may have to be accounted for when a person is elderly. It is clearly a pay now or pay later situation.

Thank you Mr. Chairman.

STATEMENT OF REPRESENTATIVE RALPH REGULA

Mr. REGULA. It is interesting to note that in 1984, the Gallup did a poll, and 79 percent of the respondents were of the impression that Medicare covered all the potential costs that they would have as elderly. I think that is a common illusion that exists, and not until people are faced with catastrophic costs do they suddenly realize that Medicare does not cover everything and that their own financial resources are put at risk as a result thereof.

I commend you, Mr. Chairman, for addressing this problem and calling this hearing because it is one that we have failed to act on in terms of either a public—adequate public response nor have we encouraged the private sector to deal with it.

The President did appoint a commission that has just completed its recommendations, and among other things they consider offering as an option an IRA that could be used as an alternative for individuals so that they could provide funds to deal with catastrophic costs. This is embodied in some legislation that I have introduced.

It is interesting also to note that in 1986 there will be 11 million Americans that will be faced with a catastrophic illness of some type or another and, therefore, need a program that will address this problem for them. I think probably the final answer should be a combination of public and private sector initiatives, and I hope that out of this hearing we can develop some ideas, and I look forward to hearing from each of the witnesses.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Regula follows:]

PREPARED STATEMENT OF REPRESENTATIVE RALPH REGULA

I commend our chairman for his diligence in pursuing this lapse of direction in the basic health policies of our nation. To date, both the public and private sectors have failed to establish any comprehensive plan for dealing with the catastrophic and long-term care needs of the elderly and disabled.

Health is part of an individual's human capital and must be invested wisely. Unfortunately, we do not possess the sole ability to control our own health. Although the type of lifestyle and decisions regarding preventive health are primarily ones own, circumstances may develop that inflate cost beyond what the average patient can be expected to pay. It is these people, the victims of catastrophic illness, who are forced into financial and emotional bankruptcy by the dictates of a system that is the result of inaction. Those who are at risk are all Americans, both young and old.

Under current law, Medicare beneficiaries, and the public in general, are largely uninsured or under-insured against the cost of prolonged care in a hospital, nursing home, or within their own home. Over 11 million older Americans will suffer from some form of chronic catastrophic disease this year. In 1986, it is predicted that approximately one million persons will fall into poverty and onto the welfare rolls as the result of the costs of catastrophic medical care.

Unlike many problems, few Americans realize Medicare and most private insurance supplements fail to adequately cover catastrophic illnesses. In a 1984 Gallup Poll survey, it was found that 79 percent of respondents mistakenly believed that Medicare pays the costs for care in a nursing home.

Recently, the President's Private/Public Sector Advisory Committee on Catastrophic Illness released their initial findings regarding catastrophic and long-term care. Listed as an option which deserves careful consideration was the medical IRA or other similar savings mechanism. This recommendation is similar to legislation, H.R. 4149, which I introduced earlier this year.

Momentum continues to build for the development of federal policy, policy which has heretofore been indifferent at best. Our distinguished chairman has also offered legislation regarding this matter. As we work toward the most appropriate answer we have joined together to evidence a firm bipartisan resolve to provide for the necessary care of these people. Although our approaches vary each moves toward the basic goal of providing adequate catastrophic and long-term care to Americans.

I am confident that the testimony to be provided by the highly acclaimed panel of witnesses before us will most certainly provide an insight into the problem and how to serve the best interests of the aged.

The CHAIRMAN. Thank you.

The Chair now recognizes Mr. Bonker.

STATEMENT OF REPRESENTATIVE DON BONKER

Mr. BONKER. Thank you, Mr. Chairman.

I, too, would like to commend you for sponsoring this timely hearing. While this is the Select Committee on Aging, when it comes to health care and answers, it is certainly an issue that spans the generations, so I commend you. For senior citizens, I think it is obvious that most elderly Americans depend heavily on Medicare for health protection.

When I served as a staff assistant on the Senate Select Committee on Aging in 1964, when Medicare was enacted, the promise at the time was that Medicare would be comprehensive and that senior citizens would no longer have to worry about health care. Now 20 years later, we find that Medicare covers only about 38 percent of the related health costs. Indeed, seniors are spending about 15 percent of their disposable income for health care.

So somewhere Medicare hasn't really fulfilled that early promise, and I think this committee at some point will have to address that issue. Indeed, this is a good starting point.

I would like to take just a moment, Mr. Chairman, to plug legislation that I have introduced that would indeed make Medicare more comprehensive by really providing another option in Medicare to extend full coverage under parts A and B so that seniors wouldn't have to go out and acquire medigap insurance. Some of them are fraudulent policies, other times seniors are in a position that paying for addendum coverage is hard.

I think the idea is to provide more comprehensive coverage under Medicare that would be possible through an increased premium so that there would be no Federal outlays. Another option is beneficiaries would be able to purchase prescription drugs used in the treatment of chronic illnesses. These are gaps in the Medicare program, and I think Congress can address these problems without having to place undue burdens on the current budget.

So I am hopeful, Mr. Chairman, as we proceed with this vital issue under your leadership that we can indeed narrow our focus so that we can meet the earlier commitments made by Congress to elderly Americans.

I look forward to the distinguished panel that we have scheduled to testify today.

The CHAIRMAN. Thank you, Mr. Bonker. Before we call our first witness, I would like to take this opportunity to submit several of our colleagues' prepared statements for the hearing record. Hearing no objections, so ordered.

[The prepared statements of Representatives, Lloyd, Snowe, and Bentley follow:]

PREPARED STATEMENT OF REPRESENTATIVE MARILYN LLOYD

I BELIEVE IT IS IMPORTANT FOR THIS COMMITTEE TO CONTINUE ITS FOCUS ON A PROBLEM THAT IS CATASTROPHIC IN SCOPE --- NOT ONLY FOR THE ELDERLY, BUT FOR EVERY AMERICAN WHO IS EITHER UNINSURED OR UNDERINSURED AGAINST THE RISK OF ILLNESS.

AT A CONGRESSIONAL HEARING WHICH WAS HELD IN CHATTANOOGA, TENNESSEE, IN MARCH OF THIS YEAR, WE HEARD WITNESS AFTER WITNESS DOCUMENT THE INADEQUACIES OF THE MEDICARE PROGRAM, WHICH, AS WE KNOW, OFFERS LITTLE IF ANY PROTECTION AGAINST THE RAVAGES OF CHRONIC AFFLICTIONS THAT REQUIRE LONG-TERM CARE.

MOST FAMILIES HAVE THEIR HANDS FULL JUST TRYING TO COPE WITH THE EMOTIONAL STRAINS OF CARING FOR A LOVED ONE WHO HAS BEEN STRICKEN WITH A CHRONIC DISEASE OR ILLNESS. WHEN YOU ADD TO THIS STRAIN THE COST OF PROVIDING CARE THAT IS NOT COVERED BY INSURANCE, THE COMBINATION CAN HAVE "CATASTROPHIC" CONSEQUENCES FOR THE FAMILY. AND, WHEN THE FAMILY'S RESOURCES ARE EXHAUSTED, THE BURDEN IS THEN PASSED ON TO THE COMMUNITY. EVEN THOSE WHO CONSIDER THEMSELVES FINANCIALLY SECURE CAN BE PAUPERIZED BY THE COST OF PROVIDING UNINSURED CARE FOR THEMSELVES OR A LOVED ONE OVER AN EXTENDED PERIOD OF TIME.

MOST OF US WORK HARD ALL OF OUR LIVES TO BUILD OUR OWN "SAFETY NET". WE WANT TO BE INDEPENDENT. WE DO NOT WANT TO BE A BURDEN ON OUR FAMILIES OR OUR COMMUNITIES. OUR 'SAFETY NET' IS USUALLY STRONG ENOUGH TO SUPPORT US SO LONG AS WE CAN STAY IN RELATIVELY GOOD HEALTH. WE STRIVE TO KEEP OURSELVES FIT BECAUSE WE KNOW THAT IS THE KEY TO OUR INDEPENDENCE. WHAT MOST OF US FEAR MORE THAN

DEATH, IS THE THREAT OF A MENTALLY OR PHYSICALLY DEBILITATING ILLNESS OR DISEASE THAT COULD DESTROY OUR SAFETY NET AND WITH IT THE QUALITY OF LIFE THAT WE HOLD DEAR.

IF WE AS A SOCIETY TRULY BELIEVE THAT HAVING ACCESS TO APPROPRIATE AND AFFORDABLE HEALTH CARE IS AN AMERICAN RIGHT, THEN IT IS TIME FOR US TO RECONCILE OURSELVES TO THE FACT THAT WE HAVE A LONG WAY TO GO IN MEETING THAT PROMISE.

I THINK IT IS TIME FOR US TO TAKE A GOOD HARD LOOK AT WHAT IS HAPPENING TO PEOPLE WHO ARE CAUGHT UP IN THE HEALTH INSURANCE AVAILABILITY AND AFFORDABILITY CRISIS --- THE 30 MILLION PEOPLE WHO ARE TOTALLY UNINSURED AND THE MILLIONS OF OTHERS --- INCLUDING THOSE ON MEDICARE --- WHO ARE UNDERINSURED WHEN IT COMES TO CHRONIC HEALTH PROBLEMS THAT REQUIRE EXTENDED CARE.

SOME OF US IN THE CONGRESS HAVE ALREADY OFFERED PROPOSALS TO DEAL WITH THIS CRISIS, AND WE'RE EAGERLY WAITING ON THE ADMINISTRATION'S PROPOSAL, SO THAT WE CAN PROCEED TO DEVELOP WHAT I HOPE WILL BE A COMPREHENSIVE ANSWER TO THIS MOST PRESSING PROBLEM.

I WANT TO THANK TODAY'S WITNESSES FOR HELPING THE COMMITTEE TO DOCUMENT THE DIMENSIONS OF THE PROBLEM. THEIR TESTIMONY WILL BE OF GREAT VALUE TO THE COMMITTEE AND THE CONGRESS.

PREPARED STATEMENT OF REPRESENTATIVE OLYMPIA J. SNOWE

Mr. Chairman, I want to commend you for holding this hearing to examine the problems of those who have little or no health care coverage.

It is indeed unfortunate that more than thirty million people in this country go without such vitally important protection as health insurance. While some of those who are at risk are laid-off workers, the vast majority are employed people and their dependents. Many self-employed individuals and those working for small companies without health care coverage cannot afford to purchase their own health insurance. More than 9 million employed persons are uninsured and together with their dependents this group accounts for three-quarters of all persons who lack coverage. One third of the uninsured are children and two-fifths of the uninsured children live in families headed by a female.

It is not surprising that many of these people go without needed medical care. In many situations it is necessary for a parent to choose between placing food on the table or getting needed medical care.

The lack of sufficient health insurance also is becoming a serious problem for hospitals across the country. In 1982 alone, hospitals in the U.S. provided between $6 and $7.5 billion of unpaid care. Many hospitals will not now provide uncompensated care, and in turn this places human life in serious jeopardy. I know we have all heard stories of pregnant women or ill patients being denied admission to one or more local hospitals.

It is hoped that the recent upward trend in the number of uninsured people may be curbed by a provision in the Consolidated Omnibus Budget Reconciliation Act requiring all employers to include a continuation option for former employees. The continuation of the group health insurance will enable widows, divorced spouses, spouses of Medicare eligible employees and dependent children to continue for three years, at their own expense, on a group policy. Terminated employees, except in cases of gross misconduct, must be provided with an 18-month continuation option.

The COBRA provision, however, does not eliminate the problem of the uninsured and the underinsured. Many small employers cannot afford to have a health plan, and many elderly people covered by Medicare cannot afford to purchase Medigap insurance.

Mr. Chairman, I look forward to hearing from the excellent panel of witnesses who promise to shed further light on this serious problem.

PREPARED STATEMENT OF REPRESENTATIVE HELEN DELICH BENTLEY

It is a fact that the growing number of uninsured and underinsured persons and the increasing numbers of poverty stricken health care recipients have given momentum to comprehensive health care legislation. I commend the Chairman for his insight on the issue of health care and agree with his decision to explore and implement effective health policies. For this reason I was compelled to call for a field hearing in April...a hearing which explored out-of-pocket health care costs.

Health care, especially for the elderly and those who have experienced catastrophic illnesses, is a necessity. Affordability, often scaled down by sacrificing quality, is no longer a tangible goal.

Health care is a right, not a privelege; all citizens should have access to affordable health care plans. It is a disgrace when health care statistics are so glum in a nation which has so much to offer. An estimated 40 million persons are now without health insurance, a 25 percent increase since 1977. Unemployment, widowhood, divorce and early retirement account for this astronomical figure.

Similarly, there are many millions of persons who are underinsured. Their existing health care policies are inadequate and they are not assured of access to needed health care nor are they protected from catstrophic health costs.

Lack of sufficient insurance effects not only these peoples' lives should they face catastrophic injury or illness, but it also effects the existing medicaid and medicare policies. It seems to prove the addage "what comes around goes around." This committee must correct the inefficiencies in our current system. . . we must take action now to improve our system. I welcome the witnesses and am anxious to hear their testimony. Testimony which I hope will enlighten the Members of this Committee.

The CHAIRMAN. Our first witness this morning is Joyce Gordon, who will convey to us the personal tragedy of being underinsured. Her 17-year-old daughter suffered a severe brain injury in an automobile accident. The insurance companies terminated payment for the $8,000-a-week cost of hospitalization because they just came to the conclusion that the daughter was not making enough progress in the recovery. The Gordons will have to bear most of the cost of care for their daughter.

This is a good example of the suffering that goes on among families throughout the United States. I appreciate Ms. Gordon's willingness to share their personal tragedy with us. I know it is not easy, but we greatly appreciate your presence and ask you to proceed in any manner you desire.

STATEMENT OF JOYCE GORDON, FORT WASHINGTON, MD, MOTHER OF BRAIN-INJURED CHILD

Ms. GORDON. Thank you, Mr. Chairman, and committee members for the opportunity to share with you the details of an experience that my family and I have been living through for the past 10 months. It is an experience of which you hear about or think only happens to others but could never touch you or your family.

My first-born child is 17 years old and lies in a semicoma state today. Karen was 16 years old when she was injured. She, her sister, and three other teenagers were returning home from a church youth fellowship meeting on November 18, 1985. The car, driven by a classmate, swerved to miss an oncoming car head on and in doing so missed the car but struck a telephone pole. Karen, the only passenger wearing a seat belt, was the only one severely injured in the accident. She was transported by helicopter to the shock trauma unit at Prince Georges General Hospital where sometime that night the doctors told us she was in a coma and had suffered severe brain damage. From that night on, there have been many emotional and stressful moments brought on by this devastating event.

A severe head injury can radically change the life of the individual and family. A serious head injury results in the loss of consciousness or coma. The state of unconsciousness may be hours but also may last for an extended time period. Experience has shown that the longer the coma, the more likely that the person will suffer functional deficits. Intellectual impairment problems, behavioral disorders and related physical disabilities are some of the problems likely to occur. Rehabilitation for the person and counseling for the injured person are often needed for months or possibly years. Head injury patients who are not rapidly admitted to intensive rehabilitation programs require twice as long a rehabilitation period as those rapidly admitted.

Karen began a therapy program at Mount Vernon Rehabilitation Center in Alexandria, VA on January 16, 1986. Her care concentrated first on overcoming physical problems, such as high fevers, infections, and fluctuating vital signs. Once these were under control, she began her program of learning how to live again. Imagine hearing voices but not comprehending the meaning of what is being said. The sounds you hear are lost in a jumble, and you can't

remember how to respond to the words. You see objects, familiar objects, but you can't remember what they are for or how to use them. You have forgotten how to do all of those things that we take for granted, like brushing your teeth. You hear people talking to you, helping you walk, gently leading you back into a world that has been lost to you for an infinite period of time. This is where Karen exists today.

We decided to bring Karen home as opposed to placing her in a nursing care facility and continue her care as much as we could after we were told by the staff at Mount Vernon that due to Karen's slow progress our insurance companies would no longer cover her hospital costs.

My husband's major medical insurance reads as such, "If you are admitted to a specialized hospital (of which Mount Vernon is) approved by said plan, you will receive a credit of up to 85 percent toward the usual charges of that hospital for 150 days." My insurance coverage reads like a photocopy of the above. One hundred and fifty days, which is approximately 5 months of time, to recover from a severe head injury. One of Karen's doctors told my husband and I very early during Karen's illness that the brain was very much like the nervous system in its recovery—slow and deliberate. It could take as long as 2 years to heal. Two years and the insurance companies gave us 5 months. Therefore, you can imagine our anger when we were told the insurance company felt Karen's progress was slow.

Head injury survivors are a new group. A few years ago, Karen would not be here, but today 50,000 to 70,000 severe head injury patients survive each year. Statistics state the cost to provide care for a head injury survivor for life is anywhere from $4 to $9 million.

My husband and I had always considered ourselves among the fortunate, good jobs with good benefits, good kids, an overall good life, but the emotional and financial stress of this catastrophic illness has created a very tense environment. Add to this frustration and helplessness in trying to get assistance. We find that because we are classified as "middle class," own a home and are not on the brink of bankruptcy, we qualify for no assistance. We are among the under-insured—that growing number of people due to the wonderful technology of modern medicine which is saving more and more lives. Karen's care at home cost approximately $2,000 per month, 10 percent of which is covered by my insurance. Ten percent is a very small percentage indeed. A family with no savings, investments, or other means of additional income could be totally wiped out. It is easy to say that comprehensive programs are needed. it is another matter to recognize that need and then to act upon it.

Our story is just one example of thousands out there in similar situations who found out that no family is exempt from this type of tragedy. They say everything happens for a reason. I would like to think that Karen's suffering has some meaning. If that reason is to help alert you and the public of the financial catastrophes experienced by individuals and families who not only are lacking insurance but those who have inadequate health insurance as well, then so be it.

Thank you.

The CHAIRMAN. Thank you, Mrs. Gordon.

The next witness is a distinguished gentleman, a young man who just turned 80 years old on August 26. Dr. Sabin, may I wish you a belated happy birthday and I understand that you continue to be as active now as you have been in the past, and I can understand why. You have had an excellent career and made a tremendous contribution to humanity. Dr. Albert Sabin is a biologist and is most known for the development of the Sabin oral vaccine.

In recent times, he was the recipient of the Presidential Medal of Freedom, the Medal of Liberty, all due to his excellent work. This gentleman has saved thousands upon thousands of individuals from a disease that I remember crippled thousands at one time.

It is a real pleasure to ask Dr. Sabin to proceed in any manner that he may desire. Please proceed, Dr. Sabin.

STATEMENT OF ALBERT B. SABIN, M.D., DEVELOPER OF SABIN POLIO VACCINE; RECIPIENT OF MEDALS OF FREEDOM AND LIBERTY

Dr. SABIN. Mr. Chairman, members of the committee, first of all, thank you very much for your kind remarks and for inviting me to this hearing. Unfortunately, much unfinished business has prevented me from preparing a statement, and I had no time to even organize my thoughts until this morning, and here is what I came to.

I asked myself what I could contribute as an 80-year old physician who has spent his entire life in medical research rather than in medical practice. Well, since I am here, I hope you will permit me to express a personal view on how the explosion of new money provided by medical research for medical practice is to a large extent responsible not only for the excellent health care that is apparently available to the majority of Americans, but also for a medical practice that too frequently has lost its very important components of human compassion and its availability to all, regardless of ability to pay.

There was a time when medical practice was about 90 percent human compassion and about 10 percent knowledge. That was in my youth. Now, with all the new knowledge that medical research has provided and must continue to provide for the best possible health care, the old system leaves almost no time for the essential human compassion. Compassion without knowledge is helpless and knowledge without compassion is insufficient for the practice of medicine.

The most important current challenge, in my way of looking at it, is how best to achieve the desirable objective of combining knowledge with compassion in the best possible doctor-patient relationship within a framework that meets the justifiable expectations of society for optimal human health care without reference to the ability of many individuals to pay the ever-increasing and currently almost prohibitive costs of such care.

Medicine has been and must continue to be professional men and women dedicated to the relief of human misery. It must not become a business for profit. I deplore the increasing commercial-

ization of health care. Sure, it costs money, a lot of money, to provide decent health care to all. I believe it can and should be done in a way that highly trained physicians and allied health professionals are properly compensated, that hospitals are used not for the physician's convenience, as it sometimes is, but only for services that cannot be performed equally well in ambulatory health care facilities.

The old system—and I think here comes the rub—the old system of compensation by fee for each item of professional service or for each item of material or service used in a hospital, like so many items in a supermarket, does not leave the physician striving for ever enough income, enough time, for human compassion, and makes a hospital a business organization for profit that is not compatible in my view with the best health care at a price that the individual American and society can afford.

Let me now mention some of the problems and what I think may be an approach to overcome them. The problem resulting from extensive new knowledge is the extraordinary degree of specialization that it requires now to deliver health care. We cannot turn back the clock. We cannot do without it. I have seen reports estimating that currently about 90 percent of all physicians in medical practice are specialists of one kind or another, and presumably there are 60 or more different specialties.

It used to be the other way around years ago, and I believe that what we need now as a result of this is not merely some relief, temporary however it may be necessary, a physician knows that very well when he approaches a complex problem, but a new approach to the delivery of health care, and that is we really need a new kind of specialist, a specialist that I would call a total care physician.

Now, a total care physician is quite different from our so-called primary health care physician, which we already have, the family physician, which we already have, or the general practitioner, which we already have. He must be a specialist who knows what all the other specialists' specialties can provide for the proper handling of a patient, and then he must also be the person to whom the reports of the specialists are addressed, and then he is the person who deals with the patient in a compassionate way. And in order to have time to do that, he cannot continue in the present system where he gets paid for every little thing that he does.

For that reason I consider, Mr. Chairman, the statement that you have in your proposal for a long-term solution of the problem, health maintenance organizations are at the very bottom of this, and it is not anything new or different in the United States. There have been excellent health maintenance organizations, like the Kaiser plan, which was in World War II, and there are many more, but I regret very much that this also has become a commercial activity, and I think it should not and it cannot.

A proper health maintenance organization should involve total families from beginning to end, should have large numbers in order to make it operable, and, therefore, it should also provide prepaid total health care for the American people, and in such a system the total care physician would be the king pin, and he must be the same physician that sees the patient every time the patient

comes and not somebody different each time. And he is in the same place, in ambulatory health care facilities rather than hospitals. There are sufficient specialists medically for the patient to contact and obtain the necessary workup, also helped by allied health professionals who don't need all the training that a physician has.

And I think that only when such a system—which already exists in the United States but I think is being badly implemented by too many improper health maintenance organizations—when this comes, there will be a situation in which a doctor can still deliver the best possible care and be dedicated to the relief of human misery without thinking what he gets for it. But he should be properly compensated.

And then I think any system must involve a method for people who cannot afford to pay to become members of such prepaid health services.

I want to conclude, Mr. Chairman, with a conviction I have somehow developed over the years that in a civilized compassionate nation, there can be no place for a system that deprives uninsured and underinsured people of access to the same quality of health care, the same quality I say with malice aforethought, so to speak, the same quality of health care that is the privilege of those who can afford the best.

Thank you very much.

The CHAIRMAN. Thank you, Doctor. The next witness is the president of the National Education Association, Ms. Mary Hatwood Futrell, who has focused national attention on the need to improve the quality of education. Her recent efforts in that cause include launching Operation Rescue, a national campaign to combat illiteracy and the school dropout problem, and serving on the Carnegie Forum on Education.

Ms. Futrell will testify on two critical elements in America's future. No. 1 will be our children. No. 2 will be their teachers. She will focus on how their lack of adequate health insurance threatens the future of all Americans.

There is a vote on the floor. We will recess and hear your statement immediately after we return. Thank you.

[Recess.]

The CHAIRMAN. The hearing will resume.

Ms. Futrell, would you please proceed in any manner you desire.

STATEMENT OF MARY HATWOOD FUTRELL, PRESIDENT, NATIONAL EDUCATION ASSOCIATION

Ms. FUTRELL. Thank you very much, Mr. Chairman.

Mr. Chairman, and members of the committee, I am Mary Hatwood Futrell, president of the 1.8 million member National Education Association.

NEA's interest in the issue of health care in this country stems from our interest in advancing good public policy and from our interest in the welfare of all Americans, but especially that of our members and their families.

It stems from our deep concern about the well being and future of America's children and it stems from our deep commitment to

quality education for all, for there is a direct correlation between health care and the learning process.

Illness—particularly chronic, debilitating illness—is one of the most devastating things that affect American families. Not only does a serious illness exact a physical toll on individuals, it can create severe emotional and financial hardships for an entire family. The fear of succumbing to such devastation haunts many Americans.

The repercussions of such physical and financial hardship extend to the widest reaches of a family. When the victim is a child, the burden is all the more painful. But children are also prey to the psychological effect on families, the demands of time that rob them of attention, and the economic consequences that can trap them in lives of limited hope and opportunity.

There are many who believe that health insurance protects the majority of Americans, but—between those who have no health insurance coverage at all and those whose protection is entirely inadequate—the truth is otherwise.

An estimated 35 million Americans have no health insurance at all, including 26 million working families. Conservative estimates project that more than one-third of the uninsured are children.

NEA is also concerned about the extent of coverage in private and public family health plans. In response to rapidly rising health care costs, health insurance providers are discouraging reliance on health insurance through high copayments and deductibles, often to the detriment of those covered. The Commerce Department reports that the typical costs for a family of four, including deductible and copayments, was between $500 and $700 a year in 1985. This approach discourages preventative examinations and treatment which could reduce the need for more expensive remedial care.

Our Nation clearly has the resources and the technology to treat and prevent a broad array of physical ills. To perform medical miracles to some and deny basic health services to others is a national shame. The United States is the only industrialized nation in the world, besides the Republic of South Africa, that does not provide some type of national health insurance.

The impact on the classroom. The effects of inadequate and uneven access to health care on academic performance begin well before a child starts to school. Inadequate prenatal and early childhood care, for example, can retard a child's intellectual development, a setback which is extremely difficult and expensive to compensate for in remedial education programs.

Health problems can cause obstacles to learning in direct ways. Far too often we find children who appear to have learning disabilities, but who instead are suffering from malnutrition or treatable diseases. Many students are compelled to drop out to care for a sick family member or to work to support the family when the primary earner is incapacitated.

Education and health issues are related in other ways. Children are susceptible to many minor illnesses in the school setting, and yet not all families can afford adequate treatment. Schools are asked to play an important role in health care, through such efforts as requiring immunization and screening for hearing and

visual problems. Schools are also held responsible for identifying victims of physical and sexual abuse or for identifying those who are chemically dependent.

Schools can play an appropriate role in coordinating health and other services. But as a society, we must ensure broader access to programs for preventative health care and treatment.

Deficiencies in access to health care are serious problems for education employees themselves.

According to Education Research Services, only 34 percent of America's public school districts provide fully paid family coverage, while 84 percent of the public school districts provide fully paid single coverage. The cost of purchasing group family coverage is prohibitive for far too many education employees, while the consequences for not being covered are devastating.

The average teacher salary for 1985-86 was $25,250, while the average income for teacher families in 1985 was approximately $39,000. The costs of purchasing family coverage—even for those with access to group rates—represents some 17.5 percent of an individual's take home pay for the average single-income teacher family and more than 11.5 percent of the average teacher family. But there are many teacher families whose income is far below the average. And adequate family coverage is even farther out of reach for many education support employees, as well as retired education employees of all job classifications.

Clearly, to continue to rely on private health insurance providers will only perpetuate the inadequacies and deficiencies of the current system. There is a role for local and State governments in providing quality health care insurance, at the very least, for all public employees. The reality is that such universal coverage is still a long way off, and the trends are not favorable.

If we are to ensure quality health care for all Americans, the Federal Government must play a leadership role. Therefore, we subscribe to the following principles.

Principles of a national health insurance plan:

One, NEA believes that access to affordable, quality health care is a basic right of all Americans.

Two, Federal health care legislation should be built on the solid foundation of social insurance established in such programs as Medicare and Social Security, and should not be means-tested.

Three, it must be universal in scope and comprehensive in coverage, including preventive, acute, rehabilitative, and long-term services in and out of the hospital.

Four, Federal health care legislation should include specific standards for quality assurance.

Five, the national program must help contain health care costs.

Six, the administration of the program should be a state responsibility, with specific minimal standards.

Seven, the Federal program should encourage innovation in the development of organized systems of health care delivery and finance.

Eight, a national advisory board with equitable representation of consumers and health care providers should be established and empowered to make recommendations to the executive and legislative branches for future development of the program.

Nine, nothing in the program should force public employees in states which have established their own statewide health care plans to become part of the Medicare system, nor should it discourage the development of comparable state health programs.

In conclusion, Mr. Chairman, we applaud your initiative in introducing H.R. 5070, and we welcome these hearings as a sign of renewed congressional interest in a truly comprehensive health care plan for all Americans. Your bill properly combines a number of related health programs and extends benefits in areas where such extensions are sorely needed.

It is imperative that the funding sources of a national health care plan be stable and adequate to do the job properly.

The urgent need for a comprehensive health care plan compels us to reexamine our national priorities. It is our hope that this reexamination will result in the development of programs which provide quality health care and quality education and ultimately result in the strength and prosperity of our people and our Nation.

The United States is the only industrialized nation in the world besides the Republic of South Africa that does not provide some type of national health insurance. The urgent need for a comprehensive health care plan compels us to reexamine our national priorities. It is our hope that this reexamination will result in the development of programs which provide quality health care and quality education, and result in the strength and prosperity of our peoples and our Nation.

Thank you.

[The prepared statement of Ms. Futrell follows:]

PREPARED STATEMENT OF MARY HATWOOD FUTRELL, PRESIDENT, NATIONAL EDUCATION ASSOCIATION

Mr. Chairman and Members of the Committee:

I am Mary Hatwood Futrell, president of the 1.8 million-member National Education Association. We appreciate this opportunity to testify on a comprehensive plan to address the health care needs of the American people. While we are deeply concerned about this issue as it affects our nation's people as a whole, our testimony today will focus on the education employees of this country and the children we serve in the public schools.

NEA has long supported the establishment of a national health policy that will meet the needs of all Americans. NEA's support for such a plan, reaffirmed at our national convention this past summer, is based on the belief that access to adequate health care is a right of every citizen. We believe that a national health insurance plan should be supported and funded by the U.S. Congress, that the plan should encourage diversity and flexibility in the provision of health care services, and that this plan must be mandatory and be provided by both public and private agencies that have substantial consumer representation on their governing boards.

NEA's interest in this issue stems from our interest in advancing good public policy and from our interest in the welfare of our members and their families. It stems from our deep concern about the well-being and future of America's children. And it stems from our deep commitment to quality education for all, for there is a direct correlation between health care and the learning process.

The extent of the problem

Illness — particularly chronic, debilitating illness — is one of the most devastating things that affect American families. Not only does a serious illness exact a physical toll on individuals, it can create severe emotional and financial hardships for an entire family. The fear of succumbing to such devastation haunts many Americans.

The repercussions of such physical and financial hardship extend to the widest reaches of a family. When the victim is a child, the burden is all the more painful. But children are also prey to the psychological effect on families, the demands of time that rob them of attention, and the economic consequences that can trap them in lives of limited hope and opportunity.

There are many who believe that health insurance protects the majority of Americans, but — between those who have no health insurance coverage at all and those whose protection is entirely inadequate — the truth is otherwise.

An estimated 35 million Americans have no health insurance at all, including 26 million working families. Conservative estimates project that more than one-third of the uninsured are children.

Indications are that rather increasing, access to health care coverage is declining. According to the National Citizens Board of Inquiry into Health in America:

o In 1982 alone, at least 700,000 poor children lost all Medicaid benefits because of cutbacks in federal and state welfare budgets and in eligibility standards.

o A 95 percent increase over three years in Blue Cross/Blue Shield group health premiums has resulted in a steady drop of subscribers to the group health plan.

o The private insurance industry is responding to health care inflation by avoiding coverage of preventative care, cutting benefits, and shifting more responsibility to the consumer.

Mr. Chairman, this issue is not limited to those who lack employment. Of course, since most health insurance in this country is made available through employers, the unemployed are at tremendous risk because of a lack of health care coverage. But today, the cost of family health insurance, either through private or group plans, is out of reach of many working Americans. Between 25 and 35 percent of the American work force lacks health coverage of any kind, largely because the cost of even the most minimal health insurance coverage -- that is, a plan with high deductibles and copayments -- can consume too great a share of a family's total income.

Moreover, there is a disturbing gap between coverage for adults and for children, brought about by limitations in coverage restricting such things as well baby care, immunization, and regular checkups, exacerbated by the tendency of many employer-provided health plans to provide fully- or partially-paid insurance for the worker, but not for dependents.

Inadequate coverage

NEA is also concerned about the extent of coverage in private and public family health plans. In response to rapidly rising health care costs, health insurance providers are discouraging reliance on health insurance through high copayments and deductibles, often to the detriment of those covered. The Commerce Department reports that the typical costs for a family of four, including deductible and copayments, was between $500 and $700 a year in 1985. This approach discourages preventative examinations and treatment which could reduce the need for more expensive remedial care.

Our nation clearly has the resources and the technology to treat and prevent a broad array of physical ills. To perform medical miracles to some and deny basic health services to others is a national shame. The United States is the only industrialized nation in the world, besides the Republic of South Africa, that does not provide some type of national health insurance.

The impact on the classroom

The effects of inadequate and uneven access to health care on academic performance begin well before a child starts to school. Inadequate prenatal and early childhood care, for example, can retard a child's intellectual development, a setback which is extremely difficult and expensive to compensate for in remedial education programs.

Health problems can cause obstacles to learning in direct ways. Far too often we find children who appear to have learning disabilities, but who instead are suffering from malnutrition or treatable diseases. Many students are compelled to drop out to care for a sick family member or to work to support the family when the primary earner is incapacitated.

Education and health issues are related in other ways. Children are susceptible to many minor illnesses in the school setting, and yet not all families can afford adequate treatment. Schools are asked to play an important role in health care, through such efforts as requiring immunization and screening for hearing and visual problems. Schools are also held responsible for identifying victims of physical or sexual abuse or for identifying those who are chemically dependent.

Schools will continue to have noninstructional responsibilities for the health and welfare of their students, and schools can, in fact, play an appropriate role in coordinating health and other services. But as a society, we must ensure broader access to programs for preventative health care and treatment.

Educational problems cannot be divorced from the needs of the whole child. For many students, education reform efforts are an empty promise if American children are denied full access to basic health care.

The impact on education employees

Deficiencies in access to health care are serious problems for education employees themselves.

According to Education Research Services, only 34 percent of America's public school districts provide fully paid family coverage, while 84 percent of the public school districts provide fully paid single coverage. The cost of purchasing group family coverage is prohibitive for far too many education employees, while the consequences for not being covered are devastating.

The average teacher salary for 1985-86 was $25,250, while the average income for teacher families in 1985 was approximately $39,000. The costs of purchasing family coverage — even for those with access to group rates — represents some 17.5 percent of an individual's take home pay for the average single-income teacher family and more than 11.5 percent for the average teacher family. But there are many teacher families whose income is far below the average. And adequate family coverage is even farther out of reach for many education support employees, as well as retired education employees of all job classifications.

Clearly, to continue to rely on private health insurance providers will only perpetuate the inadequacies and deficiencies of the current system. There is a role for local and state governments in providing quality health care insurance, at the very least, for all public employees. The reality is that such universal coverage is still a long way off, and the trends are not favorable.

If we are to ensure quality health care for all Americans, the federal government must play a leadership role. Therefore, we subscribe to the following principles.

Principles of a national health insurance plan

1. NEA believes that access to affordable, quality health care is a basic right of all Americans.
2. Federal health care legislation should be built on the solid foundation of social insurance established in such programs as Medicare and Social Security, and should not be means-tested.
3. A national health care program must be universal in scope and comprehensive in coverage, including preventive, acute, rehabilitative, and long-term services in and out of the hospital.
4. Federal health care legislation should include specific standards for quality assurance.
5. The national program must help contain health care costs by requiring prospective budgeting, to be worked out on a state-by-state basis.
6. The administration of the program should be a state responsibility, with specific minimal standards governing access, quality, and cost containment.
7. The federal program should encourage innovation in the development of organized systems of health care delivery and finance.
8. A national advisory board with equitable representation of consumers and health care providers should be established and empowered to make recommendations to the executive and legislative branches for future development of the program.
9. Nothing in the federal program should force public employees in states which have established their own statewide health care plans to become part of the Medicare system, nor should it discourage the development of comparable state health programs.

Conclusion

Mr. Chairman, we applaud your initiative in introducing H.R. 5070, and we welcome these hearings as a sign of renewed Congressional interest in a truly comprehensive health care plan for all Americans. Your bill properly combines a number of related health programs and extends benefits in areas where such extensions are sorely needed. Although we have not had sufficient opportunity to explore the many facets of this far-reaching legislation, we concur with its effort to provide access to quality health care, and we will be glad to work with you and your staff in encouraging further action on a full national health care plan.

We recognize that in a time of continuing deficits and Congressional efforts to deal with the national debt, financing will certainly be a sensitive issue. It is imperative that the funding sources of a national health care plan be stable and adequate to do the job properly.

The urgent need for a comprehensive health care plan compels us to reexamine our national priorities. It is our hope that this reexamination will result in the development of programs which provide quality health care and quality education and ultimately result in the strength and prosperity of our people and our nation.

Thank you.

The CHAIRMAN. Thank you, Ms. Futrell.

I would like to start out the questioning first with Ms. Gordon.

You heard the testimony of both Ms. Futrell and Dr. Sabin. I am going to ask you one general question. I don't want you to go through and describe again the problems that you have been having but I would like to ask you this question, and that is, what role do you believe the Federal Government should play in protecting families like yours from the costs of catastrophic and long-term illness? Do you agree with what Ms. Futrell has been saying and what Dr. Sabin has said. Do you have a plan of your own? Perhaps you can give us some direction.

Ms. GORDON. Basically I do agree with Dr. Sabin and Ms. Futrell. My husband and I have thought about this since being asked to participate on the panel as to what we thought the Government could do in order to assist us. Some type of national insurance program where we would be able to tap regardless of our financial situation, would be ideal.

The CHAIRMAN. Now, in the past, Ms. Gordon, there have been several bills presented that are designed to put in place a national health plan but the Congress of the United States has done nothing about it. It is my contention that the main reason for that is that the general public has not expressed sufficient interest in putting in place a national health plan.

Do you believe, Ms. Gordon, that we are ready for it now?

Ms. GORDON. Probably. With modern technology today more and more people's lives are being saved, so therefore it is beginning to touch more and more people and I think as it touches those lives that you are going to see a greater interest among the working class out there for the Government to get involved.

The CHAIRMAN. Thank you.

Ms. Futrell, you told the committee that the lack of a national health plan is a national shame. I agree with that.

Ms. FUTRELL. Yes.

The CHAIRMAN. I have made that statement before. I have also made the statement that we are the only industrialized nation in the world outside of perhaps one that does not have such a plan. But no one seems to pay much attention to it.

What do you think we can do as Members of Congress and the general voting public to arouse more attention, to let people know that not only my bill but other bills have been introduced that should be heard. How do we get attention called to these bills and to the fact we are trying to do something.

Do you have any recommendations to make to this committee as to what we can do to generate that interest?

Ms. FUTRELL. First of all, let me say, Mr. Chairperson, I think that attitude of the public is basically one which reflects a lack of information. I would suggest that perhaps the general public is not aware of the severity of the problem as relates to health care, and most people in America probably would be of the assumption that if people want health care they can get it, all they have to do is go out and pay for it, not realizing that for many people, that is not true.

I think that we do have to highlight the problem. We do have to make it a national priority and we can do that through the media,

we can do that through the hearings which you are holding, we can do that through organizations such as the National Education Association and many others which can publicize this issue in their publications, and publicize it when they work with different groups.

I think we can also call upon the leaders of the country to talk about the need to make sure that in America, the most affluent Nation on Earth, that all people have access to quality health care. Those are some of the ideas I would suggest for making the people in the country more aware of the problem, and to get support for this idea.

The CHAIRMAN. Ms. Futrell, do you think it is possible to form a coalition between Members of Congress and the education community in an effort to bring about this change that just must come?

Ms. FUTRELL. I believe that it is possible to form a coalition with Members of Congress, the education community, I would also say different constituency groups such as those representing the senior citizens, those representing children's groups, representing working families, et cetera. So I think it is very possible to form such a coalition and we would be happy to participate.

The CHAIRMAN. Is it possible, Ms. Futrell, to start talking then about a committee that would start looking into the means and ways in which such a coalition could be formed? Is it too early for that? Can we start now? Or shall we wait until next year sometime?

Ms. FUTRELL. No, I would suggest we start now. In order to get the bill through the committee, through the two Chambers, it is very important the people understand why this bill is being moved forward. If we begin the coalition now the coalition could be used to help not only inform the general public and to inform our members, but could also be used to help build strategy and help build support for the bill.

The CHAIRMAN. It is my opinion, Ms. Futrell, that the senior citizen community is ready to move. They understand what the problem is. Many are in that two-thirds of elderly who have, after 13 weeks, declared bankruptcy simply because they have not been able to meet those payments. Too many go without any help at all.

I think that that community is ready.

The educators as you have indicated, are ready. So I am going to ask Dr. Sabin and see what he thinks about the medical profession being ready.

Dr. Sabin, you made quite a statement with regard to a national health plan. You said something to the effect that it must be prepaid total health care for the American people. I agree with that. But again, you know we have been struggling over the years with bills that have been introduced in the Senate and in the House, but nothing happens.

Can we form such a coalition now and start generating the interest that is necessary so that the people make the Congress move. Will, in your opinion, the medical profession be a part of that movement?

Dr. SABIN. Let me start from the back.

The CHAIRMAN. Yes, sir.

Dr. SABIN. The medical profession is no more unanimous in their judgment than are the people of the United States unanimous about anything.

While there are people in the medical profession who would support this, I am quite certain that many would be opposed to it and very, very strongly opposed to it as they have been to all new initiatives that have been enacted and now actually are of great benefit to individual medical practitioners.

However, it seems to me that national health insurance without a change in the current system of remuneration, reimbursement for services, will not have the impact that you are looking for and I know you said that in the long run one hopes that health maintenance organizations of the best possible type will become the means by which health care will be provided.

However, it seems to me that if we are going to merely go on with the old system and provide some additional means for reimbursement, we may forget the need for the long term. I think the long term should begin now and I know one cannot do things immediately and although I have not been in the practice of medicine, I have had to deal with patients, and what a doctor has to do when he is faced with a serious problem is first of all, relieve the pain as well as we can which would be transferred to the present problem, to provide means for immediately relieving the kind of situation that Ms. Gordon, for example, has described, and others.

We cannot allow the people to continue to suffer for decades until the long-term thing is provided. I think that sort of thing will defeat any national health insurance.

Now, it is obvious to me that it will—that any change in reimbursement, any change that will move total care physicians who are properly trained—you cannot take a general practitioner now or a family health practice physician and make him a total care physician. It requires training.

But ultimately I think that change must be on a prepaid basis to make it affordable, to make it affordable for the Nation, to make it affordable for the individual.

Now, the public I think should also be informed more that the changes that need to be made are not a consequence of inflation and other things, they are not a consequence of that.

They are a consequence, as I said in my initial remarks, of the explosion of new knowledge which has made the practice of medicine at the present time quite different from what it was before and to me the situation that is different we can use the old ways of paying for it.

The CHAIRMAN. Dr. Sabin, as you know there is going to be opposition and there has been in the past to Social Security, Medicare, and everything else. Some Members of Congress will oppose it. Members of the medical profession and educators and people all over will find some objections, some opposition to almost any plan.

But that is part of the democratic way of doing things. This committee, I think, has a responsibility to try to get the various elements together to find a solution. It is all exploratory, but somewhere down the line I think that the only way we can come to some solution and actually be able to pass legislation is that there

be this kind of coalition. Without that I don't think anything can be done.

What I was inquiring of the three of you is do you see that possibility? I am an optimist. I do see that possibility. You are the experts; do you see that possibility, Dr. Sabin?

Dr. SABIN. I remain an optimist in the face of very difficult problems. But you know, you cannot wait to deal with a serious problem such as this by the gradual pressure exerted by coalitions. They are necessary—they are necessary—but the commercialization of medicine and health care in my judgment must stop.

Now, I don't know the best way—maybe if I think about it I will think of something else—I don't know the best way of achieving it, but I do not disregard the need for some immediate relief of the misery that should not postpone continuing pressure on the totally new system of prepaid health insurance in the United States because I think that will reduce the cost so it can be afforded, because many people will say we cannot afford it, you see, and of course you say we can, but there are always priorities.

The point is we must, we must. So perhaps your legislation as it is intended to do two things, provide for immediate relief within the present system of operations and at the same time begin, not postpone, but begin the complete reorganization of health care delivery in the United States on a prepaid basis.

The CHAIRMAN. Thank you, Doctor.

Mr. Regula.

Mr. REGULA. Thank you, Mr. Chairman.

Ms. Futrell, I was reading your statement and interestingly you say, "Nothing in the Federal program should force public employees who have their own system into a public system."

I think this is consistent with probably NEA's opposition to having State employees, particularly teachers, put into Social Security if they have a good system. Is that NEA's position? I am talking about the retirement system now.

Ms. FUTRELL. Yes.

Mr. REGULA. This would be consistent with that stand?

Ms. FUTRELL. Basically what we are saying, Congressman Regula, is that where we have systems which are of comparable standards that they should not be forced to participate; but what the national program would do is say to all the States, you must meet certain standards and so we would look at those States and right now I believe there are 13 States which have such health care programs for their employees, but they would be expected to measure up to the standards.

Mr. REGULA. Well, of course, as always, one of the problems of any national system is it ends up that those who are put into that system are those who are least likely to be covered by another, and yet the costs of providing that then would not—you would not want all taxpayers to pay for it because I assume that if individuals have their coverage under a State system that meets the standards, they should not have to, I assume you would not want them paying a tax to support the Federal system—or would you?

Ms. FUTRELL. No. But I think what we can do is what occurred during the 1950's from what I understand, when we first put into effect the Social Security Program. We allowed the people to vote

as to whether or not they wanted to operate out of their old system and in many States they voted to opt out and to opt into Social Security, and in others, they decided to stay with their system.

I think that once the program is put into place—and I am optimistic that it will be passed and will inevitably become a reality—that at that time in those 13 States the employees would have the right to decide whether or not they want to participate.

But if they decide not to, they would have to meet minimum standards and we would have to look at how that would be funded.

Mr. REGULA. And you would assume they would not pay any tax toward the cost of the national system just as they don't pay anything toward the cost of Social Security.

Ms. FUTRELL. We would say, unless some other regulation—but we would have to look at that very closely.

Mr. REGULA. I think it would follow that the cost of the national health system would be borne by those who would benefit from it as we do in the case of Medicare; is that correct?

Ms. FUTRELL. That would be correct. From my understanding, I should say.

Mr. REGULA. OK. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Bonker.

Mr. BONKER. Thank you, Mr. Chairman.

Ms. Gordon, we appreciate so much your being here today and know how difficult it must be for you to share this story which we have read about in the Washington Post, but I think it is a valuable contribution to our understanding of what can happen to any family.

As we attempt to better understand insurance and health care, I think your case really provides an illuminating example of what can happen. As I understand, you are a manager working for AT&T.

Ms. GORDON. Right.

Mr. BONKER. And your husband is a manager at Safeway?

Ms. GORDON. Yes.

Mr. BONKER. Two of America's premier industries, if you will, probably offering better health coverage than most companies.

Ms. GORDON. Yes.

Mr. BONKER. At least better than what the Federal Government provides. I can attest to that.

And if you are saying to us that both of you working for prominent U.S. companies that have generous health programs, and you consider yourself underinsured, and if you consider yourself underinsured, then I think it is safe to assume that almost all Americans, if that is a definition, must be underinsured.

But I rather imagine that you are more in the category of catastrophic.

Ms. GORDON. Right.

Mr. BONKER. Rather than underinsured.

Did you feel as though you were underinsured prior to this tragedy?

Ms. GORDON. No. No, as I stated earlier—my husband and I always considered ourselves very fortunate, prior to this experience.

Mr. BONKER. You have how many children?

Ms. GORDON. Three.

Mr. BONKER. You have three children, so you have run the gamut of doctor checkups and vaccines and everything that all of us struggle with.

Ms. GORDON. Right.

Mr. BONKER. You always felt your insurance policies were adequate.

Ms. GORDON. Right—up until this point.

Mr. BONKER. OK.

Ms. GORDON. But up to this point, I never have had really a major catastrophe affect me as well.

Mr. BONKER. So we are talking basically about catastrophic. Before I get to that, let me say I think there is a category of underinsured and I think that represents the vast disparity that exists among companies and insurance firms and how these things are negotiated. I don't know how anybody can sort through an insurance policy and fully understand the nature and extent of his coverage.

I certainly cannot in the coverage that we have.

The CHAIRMAN. That is right.

Mr. BONKER. We have not even begun to dwell on the complexity of insurance policies and the forms and who pays what. I really don't know.

I don't know when I am taken, as a matter of fact, when I get to the point of who pays for a checkup and x rays and the whole gamut of things.

I think that is another dimension to this issue. It is very complex. Unless a person has a master's degree in accounting or engineering I don't know how they wade through all these forms. But we won't get into that.

I think what we should focus upon for the moment is how this government can at least provide protection against catastrophic illness in cases like yours. And President Reagan has focused on this issue as has the chairman of this committee in legislation that he has offered. It is one thing to not have insurance for whatever reason, it is another to be fully covered and then to be completely wiped out by such a tragedy.

Now, you have heard the chairman talk about the need for national insurance. In your given situation it is not so much national insurance so it would apply though it would apply to many others, but it is catastrophic protection.

Ms. GORDON. Right.

Mr. BONKER. In those policies that you and your husband had, they are probably fairly redundant, are they not?

Ms. GORDON. Yes, basically photocopies of one another.

Mr. BONKER. You both pay——

Ms. GORDON. Right.

Mr. BONKER [continuing]. Premiums for your respective insurance policies.

Ms. GORDON. Right.

Mr. BONKER. And still when a situation like this occurs, the limited coverage leaves you short.

Ms. GORDON. Right. It is basically if you read most health insurance policies, read the exclusions. We had never done that before. If you notice the list of exclusions are almost always related to long-term catastrophic illnesses.

Mr. BONKER. Why were you both paying insurance premiums *when one insurance policy would have been sufficient for your* family needs?

Ms. GORDON. Probably because we wanted to make sure we had enough insurance if anything should happen. And I guess we figured we did. If one had insurance and the other one had it, where one left off the other one could pick up. It always worked that way.

Mr. BONKER. So you were overly insured compared to most Americans who rely on one insurance policy, and still it didn't do much good.

Ms. GORDON. Right.

Mr. BONKER. Did both insurance companies terminate coverage?

Ms. GORDON. At the same time.

Mr. BONKER. At the same time.

Ms. GORDON. Yes.

Mr. BONKER. There was no way of stretching it out where one insurance—did you try that?

Ms. GORDON. Yes. We tried to see if mine would pick up where my husband's left off.

Mr. BONKER. And——

Ms. GORDON. The issue was that if one insurance company who sent an evaluator out to evaluate my daughter's progress and determined that it was slow, and it was not to their benefit to continue—if one decided that the other one went along with it.

Mr. BONKER. Were insurance companies fairly sympathetic?

Ms. GORDON. No.

Mr. BONKER. Or bureaucratic in dealing with your problem?

Ms. GORDON. No, strictly business.

Mr. BONKER. All on the computer.

Ms. GORDON. You got it.

Mr. BONKER. Yes, OK.

Dr. Sabin, just one question for you. During the previous break for voting my staff informed me that he took his 5 year old into a physician's office the other day for a preschool checkup and she received her polio booster vaccine and it cost $15, and he has a good memory, and when his older child went in for a similar vaccine 7 years ago now it was $4.

What about drug companies and the enormous costs now associated with medication or prescriptions like that which you have made possible in this country?

Dr. SABIN. Drug companies are not at fault. They have the responsibility of making a vaccine in accord with the requirements of the Government and they do that. Yet, they are submitted to the litigations which are unjustified and improper, to be decided by juries which has raised the cost of insurance against litigation to such a point that vaccines in developing countries that buy these same vaccines in large quantities, may cost like, a dose of polio vaccine may cost less than 2 cents, a dose of measles vaccine which is also required prior to entry into school may cost less than 10 cents.

In this country it has skyrocketed up to an incredible level. And I regard this as a shame and I regard it that the only thing that could stop it would be national legislation that would do away with litigations of that sort, so that any problems that might arise would be handled in a manner similar to workmen's compensation or where committees are made up of just those competent to judge will judge the issue, but no jury trials where you put up something impossible—most of the time it is not in any way related to the vaccination.

So I am not at all sure because I have not had time to read whether the forthcoming legislation, congressional legislation will do it but from what I have heard it won't. It doesn't go far enough. You have got to do away with litigation.

The epidemic of litigation in the United States is a very serious thing and it is nothing that—I think after proper congressional action is taken against litigation I do believe that the drug companies should charge only a very reasonable cost for it. I think the present cost is absolutely unsupportable.

Mrs. BENTLEY. Ms. Gordon, I am sorry I wasn't here to hear your presentation, but I did read the article concerning your daughter, and I am very sorry about it. One of the things that has come through in this questioning is, of course, you don't know what the future holds, and the difficulty you are going to have.

In another facet of home care and the difficulties, a constituent of mine came up to me the other day and said we need to do something about making medical assistance available to senior citizens who we want to keep at home rather than making them go into an institution, and the man said that his mother has developed Alzheimer's disease. He and his wife want to keep her at home and take care of her, but they can get no assistance whatsoever to do it; and, therefore, they are going to have to put her in a nursing home where she will be covered by medical assistance, and they are dreading it, and I understand why they are dreading it.

Do you think that any plan that we develop should cover cases like that as well, that we should provide home care and home assistance, as well as institutional coverage?

Ms. GORDON. Most definitely, because since bringing Karen home, we have been working with the Visiting Nurse's Association, and although they are a wonderful organization, we still find that there are times when they run short, there are times when they can't provide someone to help.

Mrs. BENTLEY. You find that very definitely the home love—and "you are our daughter" whispering in her ear and all that has been very helpful?

Ms. GORDON. Definitely. We have seen an improvement in Karen since she has been home.

Mrs. BENTLEY. Dr. Sabin, I am delighted that you made the remarks you did about litigation, because I think that is one of the catastrophes that the whole country is facing, the litigation going on. Do you and Mrs. Futrell—I wonder if you are making conflicting statements. You talked about prepayment for long-term medical care by individuals, am I right, or by families, or how would that prepayment be made?

Dr. SABIN. The procedure to be used for prepaid health insurance would have to be worked out on a basis which I am not in a position to go into detail about at the present time, except to say this, that people who cannot afford to pay their own fee for a total comprehensive prepaid health insurance, so that no matter what catastrophe happens, that is included. You cannot take things on a point—you may need it for now for the present, that is something else again. I want to give a pain killer right away, but for the long run there should be a very total comprehensive.

For those who cannot pay, I believe we, the American people as a highly civilized compassionate nation, have the responsibility for doing for those of our citizens who cannot help themselves. It is our responsibility to help those who cannot help themselves, for God's sake, we do it for dogs, and if we cannot help the human beings among us who cannot help themselves, we have passed the stage of individualism where it is your own fault if you can't do it.

I think this nation has a responsibility to those who cannot, and therefore, I would assume that in any national health insurance that would be based on prepaid comprehensive health insurance, taking in everything, taking in all care, dental, ophthalmology, everything that is not covered now, preventive, total, I think that the nation would have a responsibility for paying this comprehensive health insurance for those who cannot; and for those who can, well, I think there could be a provision for the individual responsibility for those who can, and national responsibility for those who cannot.

Mrs. BENTLEY. Supposing somebody can but chooses not to, somebody can afford it, they have the means to do it with, but they choose not to do so. Then what? What happens if they run into a—

Dr. SABIN. I am hard of hearing, and I paid for this apparatus, but it isn't always good.

Mrs. BENTLEY. If a person has the financial means to cover him or herself or his family, and they decide that they don't want to get into this prepayment or advanced coverage and then a catastrophe hits that family and at that point they cannot afford to take care of the catastrophe themselves, what do we do at that time? How would you handle that?

Dr. SABIN. Let me see if I understand the point you are making. Let me assume for a moment that prepaid health insurance is available for all, one way or another, and the there are families who don't want to participate. To me, it is very much the same like the public school system. We have education available for all and some want to have private schools. That is fine. But they pay for it. The nation does not pay for the privilege of having that which is above that which is absolutely necessary.

Now, there was another point you said in case the status changes.

Mrs. BENTLEY. Yes.

Dr. SABIN. Did I understand you correctly?

Mrs. BENTLEY. Yes.

Dr. SABIN. Well, you know, it is very difficult to write one prescription for everything, and I would think that one—the job of

good legislation is really to take care by definition of all possibilities. It is not easy, but it has to be done.

Ms. FUTRELL. I was going to say, Mrs. Bentley, the program you are describing sounds very similar to what I understand the Canadians have. They have a national health program, health insurance program, which is established on provincial lines. However, if there are individuals who desire not to participate or who like extra services, they do have the right to go out and buy it, as Dr. Sabin said. So if they want their own private physician and do not wish to participate in the plan, they have the right to do that, or if they want additional services or want to go to someone else, they have the right to do that as well. As we look at the program, perhaps we could look at some of the models which are already in existence and maybe look at the Canadian model.

Mrs. BENTLEY. Mrs. Gordon, you mentioned that you and your husband carry identical insurance policies?

Ms. GORDON. That is correct.

Mrs. BENTLEY. If one of you had carried, say, major medical catastrophic insurance and one the other, would that have taken care of your problem?

Ms. GORDON. It depends on what the second policy would have covered, but if it would have been a catastrophe type policy, then maybe yes.

Mrs. BENTLEY. Then maybe one of the solutions that could be found rather quickly is offering a choice, let's say, by AT&T or Safeway or somebody to their employees, you can either carry this kind or this kind and in a family where there is this kind, you take the other kind.

Ms. GORDON. That would have been an alternative.

Mrs. BENTLEY. That is a recommendation, Mr. Chairman. Thank you.

The CHAIRMAN. Thank you, Mrs. Bentley. Ms. Myers.

Mrs. MYERS. Mr. Chairman, I think you are all just wonderful, and I agree with almost everything that has been said, and I am very interested in what you have to say, and I am going to talk for just a minute, if I may, about some of our problems.

I sometimes, in leading into this, I give people my 1-minute description of the Federal budget. Think of the Federal budget as $1 trillion, the largest item is defense, that is $300 billion. These are rounded figures. The next largest item is Social Security, that is $200 billion, and now you have spent half the Federal budget. The next largest item is interest on the debt, that is $145 billion. The next largest item is Medicare, $80 billion, and with those four, those are the big four, defense, Social Security, interest on the debt, Medicare, you have now spent 70 percent of the Federal budget. Everything else that you can think of is in that top 30 percent, foreign aid, the farm bill, Medicaid, all of the poverty programs, education, student loans, Amtrak, small business, highways, clean air, clean water, you name it. If the Federal Government spends money for it, it is in that top 30 percent.

That means that if you look at this, we are talking about an $80 billion expenditure for Medicare, the fourth largest item, we are talking about $25 billion for Medicaid matched by the States, because Medicaid is 50-50. That means about $50 billion for Medic-

aid, and these are all very rough figures that I am kind of doing from memory. So they are not precise, and I think $8 to $10 billion for veterans health.

Now, if we have 31 million uninsured and when we are talking about prepaid insurance, I presume those 31 million don't have insurance, because they can't afford it. Now in some cases, as Representative Bentley has said, they could afford it, but they just haven't done it. But I would say the vast majority of those 31 million don't have it *because they can't* afford it, and if we have a national prepaid insurance plan, that means that the Federal Government is going to have to pay the cost for those 31 million uninsured.

We have other problems. Most of those who are insured at this time do not have catastrophic, they do not have long-term care. You have to spend down to the poverty level before you get any help with the Government in long-term care. We do not have adequate home care. There is a great deal of discussion right now, ethical concerns that could greatly increase our Medicare costs.

For instance, I don't think at the current time Medicare will pay for heart transplants for anyone over 55. There is a great deal of ethical discussion going on about that.

Now, I guess my question, and I would like you all to react to it, if we involve ourselves in all of this, we are mortgaging our children's future unbelievably. We are mortgaging our children's future right now. Now, I am not saying that anything that any of the three of you have said is wrong. If I could fix this tomorrow, I would, and I want to very much.

But what I am saying is what should be the first step? If you agree that we can't do it all at once, should we have prepaid insurance for those who can't afford insurance? Should we take some additional steps toward providing long-term care or catastrophic care? That is our problem. And I don't expect you to solve it this morning, but I would like to have your comments on it, and I thank you for allowing me to take this time, Mr. Chairman.

Ms. FUTRELL. Well, first of all, I do not profess to be an expert regarding this issue. However, I do believe, as does the National Education Association, that this is a very important issue. I would say that when we look at the future of America, we have to look at the children, and as I look at the children who are coming up now, one of the things that scares me is that we have so many of them who live in poverty and according to the demographics, about 40 percent of the children today are in poverty, and that says to me that many of those children, if not all of them, are without health care other than what they get through the schools or what they might get from Medicaid, Medicare.

So when we talk about the future and mortgaging their future, I would have to say that that is, in my naive opinion, not a reason for not moving ahead with this item, because if we can give them all good health care and a good education, then they will be much more productive and much more self-sufficient during their adulthood.

I would say that as we put together this program, we need to bring together the best minds to develop such a program, not only as it relates to the health care component by the financing of it,

how can we get the information out to the people in the country, and how can we provide the best services, the best support, the best care not just for the children but for all people of America. That would be my primary concern. If we don't, would they want to live their life in misery, live a life knowing that they can't afford health care, would they want to live their life knowing that if they had received proper care while being cared for during the early years that maybe they would not have had some of the problems they had in school or later in life.

It seems the priority is can we develop a comprehensive universal health care program that will help all people and especially the children?

Mrs. MYERS. You would address them first, which was my question, which one of these problems should we address first, considering that we can't do everything next year, would you say the 31 million uninsured would be your first step?

Ms. FUTRELL. I would rather not take such a specific position because I would like to have us look at this problem very very carefully, very thoroughly, and come up with the most comprehensive plan we can. I would prefer a program that would allow all people to be involved, but if we can't do that, I would rely on the advice of people who know more about this than I do, because you are not just talking about young people, you are talking about old people, you are talking about people like Mrs. Gordon who thought they were adequately covered only to discover they were not.

I would be willing to look at systems such as the ones in France, Canada, England and how they started. Did they start covering everybody and then certain groups and gradually phase in other people? I would be willing to do that.

The CHAIRMAN. Does any other member of the panel wish to answer that question? Dr. Sabin.

Dr. SABIN. Mrs. Meyers, it is quite obvious that I am quite a lot older than you, and when you said mortgaging our children, it suddenly rang a bell, and the bell went back more than half a century to when the United States was undergoing a social revolution in effect, and that thing was said again and again and again, and yet the gross national product about half a century ago and even more so 50 some odd years ago, by comparison with our present gross national product, there just is no comparison, you see. So the issue of mortgaging our children, I personally believe, does not belong. The issue that we cannot afford a proper health service for the people of the United States I would also be inclined to say, knowing something about what is being done in this country, that we can.

The question is how? Now the next question I think, or maybe the first you asked, is since everything cannot be done at once, what, let's say, in my opinion, should be done first? Personally I believe that it is necessary to attack a serious problem in toto. The costs of health care in the United States at the present time are too high, and I believe that they could be markedly diminished without any interference with quality of health care. So that needs to be attended to.

The issue of whether or not something should be done right away—as a person who doesn't have much more time to live, I would say for people in a hurry, and I am still a young man in a

hurry, I would first want to address for those who don't have anything. People who are turned away from hospitals because—do you have insurance? No, I don't have insurance, out you go. You have documented how much of that takes place. That is a disgrace. It is a national disgrace.

I would make that illegal, and I would provide those hospitals that would take care of them with the funds to take care of them. No person should be denied health care on the basis of inability to pay. If we can't afford that, let's go into bankruptcy.

The second thing I would attend to would be those who are underinsured. Now, I don't know if I would call it a catastrophic illness, but 3 years ago, I was completely paralyzed, I died and was resuscitated and lay paralyzed for several months, and I had lots of bills. Even though I had Blue Cross-Blue Shield, Medicare and so on, I had lots of bills, but I could pay them.

The point is there are many Americans who cannot pay them, and then what happens to them? I think their priorities should be considered, while a system to reduce the cost of health care is being attended to, at the same time I am not a general practitioner who says we don't have the knowledge, we can't deal with this disease you have, I will give you something. You have got to give something, but you have got to attend to the problem.

I think that it is necessary to have some priorities, but the approach should be a total approach, and when I hear you include Social Security into the national budget, I have been paying Social Security for more than half a century, and until just about a month ago, when I was still getting paid by the Federal Government, Social Security got its bite, you see. Social Security is a form of existing insurance. It is not part of the budget to which everybody contributes. Now maybe it doesn't cover everything. But that cannot be part of the budget.

And Medicare, Medicaid—look—those figures can be reduced, but in some places they should be increased. Medicaid is not enough. In many instances, Medicare is not enough.

So my answer to you, yes, you need priorities, but you have got to attack the whole problem at the same time or else you will go on having problems again and again and again, and please—I think we can afford it. And I don't think this Nation is ready to go into bankruptcy.

Mrs. MYERS. Mr. Chairman, I appreciate very much your comments, and I don't want in any way for you to think that I am being argumentative. I do think that because we have a $2-trillion debt and a $200-billion deficit, when interest on the debt is the third largest item in the Federal budget, that we would not be doing our job if we did not concern ourselves with these sorts of things. And so in that respect is why I talk about it, and not to diminish the importance at all of what you are saying.

I do think we have to address these problems, but I think it is going to have to be done with some kind of priority, and just for your interest, not that this should be the top priority, the thing that I hear the most about from my constituents is the issue of long-term care, those people who—they do not realize that there is currently nothing that will help pay for long-term care for Alzheimer's disease or various other problems, the one that Mrs. Gordon

has, unless the family is willing to spend themselves into the poverty level, and then they get some assistance through Medicaid. We have made some steps with Medicaid waivers and home health care working through the States, but we still have an enormous problem there, and that is what I hear the most about from my constituents, and I thank you for your responses.

The CHAIRMAN. Mr. Vento.

Mr. VENTO. Thank you, Mr. Chairman.

You have a very distinguished panel here today. Dr. Sabin, I have been here when you have done your work. I must compliment you on your recent contribution to the Discovery Science magazine article on AIDS that you recently participated in. It was an excellent article.

Of course, Ms. Gordon, we welcome you here. I think that you all too well exemplify the problems that or constituents are exposed to and are aware of. In real life, I was a schoolteacher for 10 years, so we have a lot in common. A science teacher, as a matter of fact.

If you look at health care in the country, you find it is not doing the job it is supposed to. Medicare started out dealing with about 75 percent of the health care costs for the elderly, and now we are down to something less than 40. If you took a vote of the elderly in terms of their opinion of our prospective payment system, they would be overwhelmingly in the negative. It may help hospitals, but it doesn't do much for continuing service. Worse yet, we find that these 200 million Americans that don't have this type of catastrophic health care are not aware of it. I think the chairman's focus on this today, specifically with regard to the aged, is important because there is no way that the average family in Minnesota or any place else can plan to meet this particular need. That is almost a definition of what insurance and the Government is supposed to do—to eliminate the uncertainty that occurs. And that has only been aggravated or compounded by the new restructured underwriting that has gone on as insurance companies begin to evaluate their deeper pocket risks that they have covered in the past. Now because of the low profitability and the high liability, insurance companies have decided to withdraw from that particular market.

As we examine all our insurance policies, health insurance and others, you are going to find that there are larger voids if the unpredictable and the unlikely does occur. I think that is a good start to recognize that factor. You hear a lot about budgets, but the fact of the matter is that preventive type of health care can save money. We keep saying that, but we don't put anything behind it. We have tried to do things with programs like WIC and other programs for kids, but it is hard to educate them. You try to meet them where they are at.

You are telling us that more and more young people are in poverty. There is an interesting debate about this, that the elderly today are wealthy and that the young people are the ones that are in poverty. I submit that there would be a lot of elderly that would be in poverty too if certain policies that were advocated by the administration in the 1980's had been successful. That is to say, if the administration's modifications in Social Security and the reduc-

tions and greater reductions, in medicare had all been achieved—there would be a lot more elderly people in poverty today; and if everybody was equally miserable, I suppose we ought to be happy.

I find it startling, that conclusion. I think the failure and the reason we have this problem is due in some extent to the withdrawal of Federal or national programs that exist and the States are unable to pick up the entire program.

We need to do something on a broad basis. I think that I realize that none of you are qualified to answer, nor am I, but one of the first questions I asked when I ran for Congress 10 years ago is: What is the total dollar that we spend on health care? It is ironic that here we have the pinnacle in terms of health knowledge and of scientific knowledge with regard to health care, we lead the world in that. Yet if I evaluated how we apply that on a broad basis in terms of our population, there are a few that get very good care and many that get very poor care because of the type of system we have of distributing quality health care on a broader basis to the people that we represent.

That is evidenced with the incident with Ms. Gordon and her family's problem. I think it is evidenced with the kids that are in the classrooms that Mary Futrell is representing here today. We are just not doing the job. The fact is that the cost in terms of human resource is overwhelming. You know Dr. Hodgekinson from the Department of Education has pointed out that half the students in public schools in the 1990's will be minority students—half of them. If we don't do the job in terms of health care, in terms of meeting those kids where they are at and improving it, we have very serious problems in terms of our future.

You can't do much about it, and one of the big parts is they have to be healthy. They aren't going to learn if they are not healthy. I trust we can do it.

I also hear the discussions about balanced budgets. I think the thing to recognize is that we surely have to, when we have people that are going through the thresholds and run out of income, they fall right into the Medicare or Medicaid Programs. The welfare system is supported by the States and the National Government, and that budget is going to continue to grow. In my judgment, the growth of the Medicaid budget represents the lack and the failure of planning and permitting people to plan for their own health care needs.

As that grows and really explodes, we have to do something about it, unless we are going to take the view that we are going to withdraw and renege in terms of the basic commitment in terms of health care. We have tried every way, through Hill-Burton, construction funds. I think the mandate is clear in terms of the intent of the law, but yet we have not faced up to and are not dealing with that.

But the growth of the Medicaid budget is the failure of health care policy in this country. And we have to do something about that. It is going to only be complicated by the insurance underwriting practices that are prevalent today in terms of withdrawing from this catastrophic area.

I have no questions, but I want to commend you, Mr. Chairman, for the hearing.

The CHAIRMAN. I thank you, Mr. Vento.

I would like to thank the panel for not only interesting, but very informative information that you have given this committee.

Thank you very much.

The next panel will be made up of three very distinguished individuals. The first is the former Secretary of Health, Education, and Welfare, Dr. Arthur S. Flemming; accompanied by, Dr. Robert B. Helms from the U.S. Department of Health and Human Services, and Dr. Uwe E. Reinhardt from Princeton University.

Will you please take your respective seats.

I am going to ask Dr. Flemming to start out the discussion, and proceed in any manner he may desire.

STATEMENT OF ARTHUR S. FLEMMING, FORMER SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; AND CHAIR, CITIZENS' COMMISSION ON CIVIL RIGHTS

Dr. FLEMMING. Thank you, Mr. Chairman.

Mr. Chairman, members of the committee, I appreciate very, very much the opportunity of participating in this hearing and I certainly want to commend you, Mr. Chairman, and your colleagues for exercising the leadership that you are exercising in connection with this very, very important issue.

Forty million Americans, 1 out of 6 of our total population, are not covered by any health plan, public or private. Another 10 million are part of a health plan that provides totally inadequate coverage.

Behind these numbing figures are millions of persons of all ages who are struggling, even dying, because we are the only industrialized nation in the world, except South Africa, that has refused to make access to health care a right for everyone.

Many Americans—old, middle-aged, and young—believe that the time has come to confront this situation head on. They believe that, at long last, our Nation must develop and implement a national health plan which will contain health care costs, while bringing everyone under an adequate health care system.

Older people, for example, know that this is the only way to close the indefensible gaps that now exist in the Medicare Program for older persons and the disabled, and to deal with the health care crisis that confronts their children, grandchildren and great grandchildren.

Medicare observed its 20th anniversary in 1985. When enacted, it was expected to cover approximately 70 percent of the health care costs of the average beneficiary; today it covers only 44 percent. The average beneficiary is spending as much of her or his own funds on health care today as 20 years ago.

The reasons are well known. Costs are spiraling and there are glaring gaps in Medicare coverage—no provision for vision and dental care, loss of hearing, prescription drugs, or long-term illnesses, including home care.

Many proposals have been made to strengthen Medicare. This is a commendable goal, however it is sure to be a slow, incremental approach. We would be confronted, in the meantime, with the fact

that millions of persons in other age groups would be left completely unprotected from the hazards of the high costs of physical and mental illnesses. This would inevitably weaken public support for closing Medicare gaps and would create tension between age groups.

Medicaid—our Federal-State program for low-income people—also observed its 20th anniversary in 1985. There are many weaknesses in the Medicaid Program, but the most glaring one is that less than half of the persons who are living below the poverty line actually participate in Medicaid. There are, for example, 3,400,000 persons 65 and over who are living below the poverty line, yet only 36 percent have the protection, for example, that Medicaid provides for long-term illnesses. This protection is better than that provided by other public or private plans—but it is available only to a small percentage of those who need it.

What about the private sector? Dr. Anne R. Sommers, adjunct professor at the Robert Wood Johnson Medical School in New Jersey, in an article in the Wall Street Journal, sums up the situation as far as long-term care is concerned in this way:

> The same demographics that create the need for long-term care insurance frighten the insurance industry with the spectrum of costs badly out of balance with affordable premiums. The concern is understandable and, certainly, so far as the poor are concerned, it is unlikely that any purely private solution can be found.

What then can we do? Older persons belong to a generation that has been deeply involved in making Social Security a reality. We have shown that it is possible for America, functioning as a national community, to pool our resources to help all of our people, wherever they live, deal with what the late President Roosevelt referred to as the income "hazards and vicissitudes" which confront the families of our Nation. Our Social Security system is one of the world's greatest examples of how a people united can deal with the loss of income because of retirement and the death or disability of the family income producer.

Older persons believe that it is also possible for the United States, functioning as a national community, to pool its resources in such a manner as to make it possible for all of our people wherever they may live to deal with the "hazards and vicissitudes" of life related to the cost of health care.

That is why older persons welcome, Mr. Chairman, your leadership in addressing this issue by introducing H.R. 5070, the U.S. Health Program Act. We need a law which will control health care costs, protect quality of services and assure access to health care to all Americans. As Douglas Fraser, the chairman of the National Health Security Action Council, expressed it: "This plan—your bill—offers comprehensive health care protection to all Americans in a cost-controlled manner."

The first question I confront as I discuss this issue throughout the country, the question that I confront across the country and the one that has been covered in discussions for the last half hour here: Can we afford it? That is why I am delighted that one of the major sections of your bill deals with cost containment.

We must as a Nation recognize that we are spending billions of dollars under our present health care system that we just don't need to spend.

Twenty years ago, Canada and the United States were spending approximately 6.5 percent of their Gross National Product on health care. Neither nation had a national health plan. In 1971, Canada began to implement such a plan—a plan which also has cost containment built into it.

Today Canada spends 8.4 percent of its gross national product on health care; in 1985, the United States spent 10.7 of its gross national product on health care—the highest percentage for any developed nation in the world. Everyone in Canada has access to adequate health care; 40 million persons in this Nation do not have access to any health plan, public or private. Why this discrepancy?

An article in the New England Journal of Medicine last February reported on an in-depth study designed to determine what savings we could make in this country in administrative costs in the health care field if we should adopt a Canadian-type plan. It was concluded that we could save $29 billion a year or about 8.3 percent of our total health bill.

Think, for example, of the millions of dollars that we spend to determine whether persons are eligible for Medicaid—dollars that make no contribution to the health care of anyone. In the private sector, think of the millions of dollars that are spent for administration to determine whether persons are eligible for health insurance policies.

Then consider the savings that could be made if cost containment provisions, such as those in H.R. 5070 were in effect.

Payments for hospital care would continue to be made on the basis of a prospective payment system as is now the case under part A of Medicare. Physicians, nursing homes, home health, hospice, and ancillary services, including prescription drugs, would be paid on the basis of a prospectively set, fixed fee developed in consultation with health care providers. Future payment increases would be linked to increases in per capita gross national product. Exceptions to this payment system would be made in the case of qualified HMO's, and payments in States with approved State-sponsored cost containment program.

Yes, H.R. 5070 or any similar bill would call for cost increases in order to grant all of our people the right to adequate health care. But there would be offsets in administrative savings and because of cost containment. These are the kinds of offsets that have held GNP expenditures below those of the United States in all other industrialized nations with national health plans—plans which, unlike our patchwork system, provide everyone with access to health care.

That is why, Mr. Chairman, I believe your estimate that your plan, if implemented, would mean that our GNP expenditures would go no higher than 12 percent is sound. If anything, it is too conservative.

I am a friend of Dr. Philip Lee, former Assistant Secretary of Health, and he believes we can put into effect a national health plan such as envisaged by your bill without increasing our GNP expenditures. But let's assume that we do move from 10.7 of the gross national product to 12 percent of the gross national product. That is a price we clearly have the capacity to pay in order at long last

to alleviate the suffering that is caused by our failure to implement the right of everyone to have access to adequate health care.

H.R. 5070 would guarantee all U.S. citizens and residents access to primary, acute and long-term health care. The package of benefits incorporated in the bill is a response to the basic issues confronting our Nation in all three of these areas. I am sure that there will be differences of opinion as to what should be in the package. These differences will become a part of our national debate on this major issue and will make a constructive contribution to the ultimate outcome of that debate. The important thing, however, is that the benefits package in H.R. 5070 is an outgrowth of a clear recognition of the issues that confront the consumer and a determination to deal with—not evade—these issues.

I am delighted, for example, that the bill provides genuine hope for those who confront or fear they will confront what are oftentimes the overwhelming burdens of long-term care. We have listened to the presentation of a case history relative to those burdens here this morning. If this bill should pass, we would be responding, as a national community, to the deep-seated concerns of millions of our people, wherever they may live, in a fair, compassionate and fiscally responsible manner. I feel that it would be reasonable, as your bill specifies, to require that all but the low-income would pay up to a maximum of $500 per person per year for health care and skilled nursing home and home health costs, and up to a maximum of $1,000 per person per year for nonskilled longterm care.

The proposal to make health maintenance organizations and similar delivery systems the primary vehicles for delivering health and continuing care services is a constructive one. It could, for example, help to achieve the cost containment objectives of the bill. Here again, alternative ideas may be advanced which we will all want to explore. I feel, however, that if the Nation decides to move in this direction, major emphasis should be placed on the portion of the bill that calls for qualifying HMO's under title XIII of the Public Health Service Act, requalifying them on an annual basis, and penalizing or removing from the program any HMO which no longer meets qualification standards. Unless such provisions are vigorously and effectively implemented the national health plan would rapidly lose credibility.

I congratulate you and your associates, Mr. Chairman, on providing in the bill for the establishment of a quality assurance system. If such a system is not made an integral part of a national health plan, we will be guilty of raising the expectations of our people and then seeing these expectations change into deep-seated frustrations. I like the provisions in this section. I like the provisions dealing with prospective system under part A Medicare, for example, I think they will help to correct some of the problems we have run into in that particular area. Here again, I am sure a national dialog will result in new ideas being incorporated in the section. Personally, I would like to suggest that consideration be given to providing that the chairpersons of the local consumer advisory boards provided for in the bill also serve as members of the peer review organizations.

I know that there will be a vigorous debate over the tax package you have included in your bill in order to provide the revenues for

the trust fund from which benefits would be paid. Nevertheless, I congratulate you on putting together the package. This package, when combined with the cost containment features of your bill, demonstrates to the Nation that we have the capability of implementing a national health plan within the frame of reference of our overall fiscal situation. If sound arguments can be advanced for dropping parts of your tax package and substituting for them some other proposals I am sure that you will be happy to listen to those arguments.

The important thing is that you believe as I do that we must keep before us at all times the goal of implementing a national health plan in a fiscally responsible manner. This can be done and the provisions of your bill help to demonstrate that it can be done.

Many Americans have long sought to make access to decent health care a right for everyone.

I have participated in those efforts over a long span of time. Forty million Americans are suffering, struggling against insuperable odds to deal with the costs of health care, or living in fear because of our failure to reach that goal. These millions, their families and friends, older persons and advocates for children are ready for action.

For example, SOS, a coalition of over 100 national organizations to protect Social Security, of which I serve as cochair with Wilbur Cohen, another former Secretary of Health, Education and Welfare, after recommending a 15-point program for improving health care in the United States said:

> We favor—as the only realistic basic solution to the Nation's total health care problems and needs—a universal national health care plan with comprehensive coverage and benefits, cost and quality controls, annual budgets and a reorganized health delivery system.

The National Health Security Action Council, of which Douglas Fraser is chairman and Melvin Glasser, the director, in a recent pamphlet entitled, "A National Health Care Program—Now" concludes:

> We are at an unusual time in the history of health care. We have a unique opportunity, not to patch, not to engage in new public relations gestures but to achieve a long-sought goal of the American people—to make access to decent health care a right for everyone.

Martin Luther King, in his address at the Lincoln Memorial on August 29, 1963, warned the Nation, among other things, against taking the tranquilizing drug of gradualism.

We have taken that drug far too long in the field of health care. As I travel the Nation and speak and listen to groups of citizens, I sense that a revolt is underway against the continued use of that drug—against our patchwork health care system.

There is strong support for the thrust of H.R. 5070. I hope, Mr. Chairman, that you and your associates on this committee will take appropriate action designed to accelerate consideration of this bill by the appropriate committees of both Houses of Congress. If this happens, it will accelerate a movement which will gather momentum—a movement which is going to demand action on a national health plan—not in the distant future, but in the one-hundredth Congress.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Dr. Flemming.

Dr. Helms, Dr. Reinhardt, it is necessary for us to once again answer a roll call again. One has been called. We will recess for 10 minutes and be right back.

We will return.

[Brief recess.]

The CHAIRMAN. Dr. Helms, will you proceed in any way that you may desire. You may either read your statement or summarize it or use any method that you please.

STATEMENT OF ROBERT B. HELMS, PH.D., ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. HELMS. Mr. Chairman and members of the committee, on behalf of Secretary Bowen, I thank your for invitation to appear before the committee this morning to discuss issues and problems related to health insurance for the American people. Since my written statement is so long and detailed, I would like just to make a few informal remarks. We can go into more detail later, if you like.

The Secretary shares the concerns of the committee and of the other witnesses you have heard this morning over the difficulties that some people have obtaining the health services they need, and over the very high—even catastrophic—costs faced by a few families. The President has made clear that he intends to respond to those needs.

Mr. Chairman, there are four major financing systems that provide Americans access to the health services they require. The first such system is commercial insurance largely made available through the workplace. It has been estimated that two-thirds of all Americans—employees and dependents, retirees and those between jobs—are protected by commercial insurance.

The second financing system is public insurance; nearly 50 million people are protected by Medicare and Medicaid, and millions more through the State-financed programs that pay for health care for the poor who are not eligible for Medicaid.

The third financing system is based on State and local governments' taxes and Federal block grant funds; through the resulting services delivery programs, free care is provided by certain public facilities, and charity care is made available through nonprofit and for-profit health care providers.

The fourth financing system is the out-of-pocket payments made by every insured and uninsured person—coinsurance, deductibles, payments for supplementary services, and so forth.

These four financing systems are intertwined and interdependent, and they are constantly changing. It is artificial to weigh the impact of any component in isolation from the others or to believe that a static snapshot of any system can capture tomorrow's reality.

Attempting to look at one piece of this mosaic can result in a lack of clarity regarding the nature of the problems we face.

Mr. Chairman, there are indeed problems—problems of lack of insurance and problems of underinsurance. The testimony we have

heard this morning speaks eloquently of selective gaps that require selective solutions.

The size of the problems and the nature of the populations facing them are the subjects of a whole variety of statistics drawn from a variety of sources, and given a variety of interpretations.

While certain of these interpretations soon become conventional wisdom, I believe that we all need to be very cautious about rushing to adopt anyone's version of truth. That is one of the main points I tried to make in my written statement which has been submitted for the record.

We all agree that existing gaps must be closed with targeted solutions. As President Reagan has said, we must look for ways that "the private sector and government can work together to address the problems of affordable insurance for Americans whose life savings would be threatened by catastrophic illness."

Family financial catastrophe that is related to out-of-pocket health expenditures arises infrequently, but it has many faces: for an insured family with $50,000 of income faced suddenly with $100,000 in uninsured medical debts, there is catastrophe; for an uninsured family with a minimum wage income and a need to pay a $1,000 medical bill, there is catastrophe. Whether the costs are for acute care or long-term institutional care, the effects are equally devastating.

But the response to these problems cannot be one-dimensional. We have a diverse system of health care financing and delivery. All of the participants bring strengths to that system, all of us have a stake in making changes that are both effective and efficient, and all of these parties must participate in designing and playing a role in the solutions—employers and individuals, commercial insurers and self-insurers, individual and institutional health care providers, and governments at the local, State, and Federal levels.

Mr. Chairman, as you know in response to the President's instructions, the Department of Health and Human Services has been engaged for several months in examining the problem of catastrophic health care costs.

Three working groups have been focusing on problems of long-term care and acute care for the elderly, and on the problems of the under-65 population. I regret that my printed statement could not be more comprehensive in its discussion of findings and alternatives, but I know that you will appreciate that it would be premature for the Department to discuss this material when it has not yet been evaluated in detail by either Secretary Bowen or the President.

The problem of long-term care, especially for the elderly, is a particularly complex issue as I know I do not need to tell the members of this committee. The long-term care system in this country is a delicate balance with 70 percent of needed care delivered informally by families and friends, and with one-half of the institutional care paid for directly by beneficiaries and one-half by the Medicaid Program.

Demographic and socioeconomic changes that are already underway call into question whether this present system can be main-

tained, and questions are being increasingly raised whether or not this public-private financing arrangement should be maintained.

For some people, family care is an extremely heavy burden that is now willingly borne out of love, but at considerable sacrifice. For other people, the out-of-pocket financing of community and institutional care is straining finances, and for Federal and State Governments, the burden on the Medicaid Program diminishes over ability to meet other urgent care needs.

Very careful attention is being paid to the growth of private long-term care insurance, and we believe that there is reason to be cautiously optimistic about its future growth.

We need to remove barriers to its growth while being prudently watchful over the quality of protection it affords.

For persons who may be unable to afford private, long-term care insurance, there will certainly continue to be some public role, although just how that role should change remains to be seen. However the private and public responsibilities evolve, what is most clear is that all persons who are not yet elderly will have to face up to a need to invest in their own futures by preparing early for their long-term care needs.

Mr. Chairman, in your floor statement last June, you said, "Let us hope that we can again follow this proud American tradition and find a truly workable American solution to today's health care challenge."

The President, Secretary Bowen, and this entire administration join you and the other members of the committee in that search for a workable American solution.

Again, I thank you for the opportunity to appear. I will be glad to answer any questions.

[The prepared statement of Dr. Helms follows:]

PREPARED STATEMENT OF ROBERT B. HELMS, PH.D., ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH & HUMAN SERVICES

Mr Chairman, members of the Committee:

On behalf of Secretary Bowen, I thank you for your invitation to appear before the Committee today to discuss issues and problems in health insurance for the American people. Your invitation to testify mentioned the problems of some 50 million Americans who fall into two groups - persons who have no private or public health insurance -- the "uninsured" -- and persons who, although insured, lack some degree of protection against very high acute care out-of-pocket costs (often called "catastrophic costs").

Summary

Among persons who are uninsured and underinsured, a small number each year will incur medical care costs that will impose serious family hardships; governments, insurers, employers and others must work together to effectively address those very real needs. However, there is an implication that all people who are counted on surveys as being uninsured or somehow underinsured lack access to health care, and that this situation has created a need for radical restructuring of the Nation's health insurance. I believe that neither the interpretation nor the solution is warrented, and that the nature of the problem needs more precise definition. In this testimony, I will present a somewhat different picture that I believe can serve as a basis for agreement regarding the nature of this problem. I will make four main points:

-- First, I agree that there are selective gaps in the insurance coverage of many Americans, but these gaps are not pervasive or general.

-- Second, uninsured does not necessarily mean unprotected. Many of the uninsured have significant amounts of income and may be making a rational economic choice to self-insure. At the other end of the income scale, the very poor are protected through programs designed and managed by state and local governments.

-- Third, I agree that means should be explored for closing the gaps that do exist so that every American has access to affordable, cost-efficient health insurance and health services.

-- And fourth, solutions must build upon the strengths of our pluralistic system -- the role of the individual in meeting family and societal responsibilities within a framework of choice and enlightened self-interest; the role of the private marketplace in promoting efficiency among insurers and health care providers; and the role of governments in selectively meeting special needs. In collaboration with employers, insurers, beneficiaries, and state and local governments, we must evaluate which gaps are already being closed and what marginal additional steps would encourage and accelerate improvements.

Discussion

Estimates of the number of people who are uninsured or underinsured vary depending upon definitions, which survey is used, how responses are interpreted, and what approach is used to extrapolate to the national population or to update findings to the present. However, there appears to be some consensus around the following numbers:

-- Estimates of the number of people under age 65 who are uninsured typically range between 35 and 40 million persons. About one-half are estimated to be uninsured all year and about one-half uninsured for some period during the year.

-- The estimate of underinsurance is highly sensitive to definition. Using definitions developed by the National Center for Health Services Research, the number of persons estimated not to be fully protected against catastrophic acute care costs is between 10 and 15 million persons.

There are two major perspectives from which look more closely at these numbers. One perspective is family income, which is crucial in analyzing ability to pay premiums, deductibles, co-insurance and costs of uninsured services, and in making estimates of the extent to which health insurance and health

services costs compete in the family budget with costs of daily living. Families with low incomes are less likely to have private insurance, and are more likely to have public insurance and to use publicly-financed services.

A second and closely intertwined perspective is the affiliation of family members with the labor force. This orientation is important because workplace health insurance is the foundation in this country upon which health insurance is based for persons under 65 -- employed persons, their dependents, the transitionally unemployed, and early retirees. Individuals and families under age 65 without labor force attachment are significantly less likely to have private health insurance. These include the structurally (or long-term) unemployed, some early retirees, the non-working disabled, the poor elderly, and dependant children in single-parent families.

As important as is the presence or absence of insurance coverage within these groups, the comprehensiveness of the protection afforded is equally important. Some people who have private insurance protection find that their insurance is not sufficiently broad to cover their costs: either services needed are not included in the coverage, or there is no stop-loss limit on cost-sharing, or the insurer's maximum liability limit is too low. There are a variety of definitions of underinsurance, most related to what are called "catastrophic medical expenses," and I would not propose to recommend a specific definition. For the purposes of the study requested by the President, we have elected to define catastrophe in terms of the amount of uninsured, out-of-pocket costs that are incurred relative to family income. But beyond that general definition (with which not everyone will agree of course), specifics become a matter of societal judgment -- whether uninsured costs are a catastrophe when they reach 5% of income or 10%, or whether 2,000 dollars out-of-pocket is a catastrophe or 6,000 dollars or some other number.

The definition chosen will determine the size of the problem: the lower the threshold definition is set, the more families will exceed it each year. For example, we have estimated that of the non-institutionalized population, about 4.3 million middle- and upper-income families would experience a catastrophic medical expense if the catastrophic threshold were defined as 2,200

dollars out-of-pocket. But, if the threshold were raised to 4,400 dollars, the number of families would drop to 1.2 million. Using a percent of income threshold brings many more people over the threshold (especially among low-income families): if 5% of family income is the threshold, 6.4 million middle- and upper-income families would experience a catastrophic expense; but if a threshold of 15% is used, fewer than 1 million such families would be effected. To repeat the main point, the size of the problem depends very much upon the definition chosen.

I will now turn to a review of the health insurance status of families with and without labor force affiliation.

Families With A Labor Force Affiliation

It has been estimated that nearly 2/3 of Americans have workplace-based health insurance throughout or for some part of the year. Among workers, 1977 data indicated that about 57% obtained coverage directly through employment and another 14% indirectly through the insurance of a working spouse. Eighty-three percent of full-time, full-year employees had insurance. In addition to being insured, about 2/3 of persons with group insurance were protected against catastrophic out-of-pocket costs.

The equating of lack of insurance with lack of access to health care is misleading. One example for which this is especially true is uninsured persons with comparatively large incomes. Analyses done for the Department have shown that in 1980, approximately 24% of the uninsured had incomes above 300% of the poverty standard, and an additional 19% had incomes between 200% and 300% of the poverty standard. While we cannot be certain of the extent to which these estimates represent the situation in 1986, for some 40-45% of the uninsured population it is clear that they are not without the means to directly purchase many of the health services they need. Of course, their ability to successfully self-insure will depend upon their need for health services. Research shows that the mean out-of-pocket expenditures for multiple-person families without full-year health insurance and with family incomes above 200% of poverty ranged from 500 dollars to about 600 dollars in 1980.

Another group for which the effect of lack of insurance might be considered overstated is the largest age group among the uninsured -- persons ages nineteen to twenty-four -- who constitute about 18% of the uninsured. Many of these are transitioning out from under their parents' insurance protection, they tend to be healthier with few medical care costs, they have fewer assets to protect, and relatively little long-term indebtedness. It could reasonably be argued that these workers are making a rational economic choice: instead of paying premiums, annual deductibles and co-insurance, they are taking as much of their income as possible in the form of wages and planning to meet health care expenditures out-of-pocket. For most of those who do so, this will be a realistic choice. Of course, a few of these young employees will face high costs and they and their families will regret having chosen to self-insure.

A third employment-related group that has, over the years, been a matter of concern has been the transitionally unemployed, and certainly they constitute a significant (although unmeasured) proportion of the people who are uninsured for some part of the year. However, there is need for caution here as well. Research related to persons who were unemployed in 1977 showed that the majority retained health insurance protection because they had access to it by taking advantage of states' continuation and conversion requirements, or through an employed, insured spouse. This same research determined that unemployed workers in 1977 did not experience a reduction in use of health services suggesting that they continued to be effectively covered. In addition, some 24 States (including the largest ones) have elected to provide Medicaid benefits for intact families where the principal wage earner is unemployed; so, even though a survey would count some unemployed families as uninsured, the Medicaid program is available in many states if these families decide to use it.

Thus, for many families with labor force affiliation, they are either insured or have the economic status to afford to purchase health care themselves. For some other families, however, even though they have some attachment to the labor force, insurance is either unavailable or unaffordable. These are most frequently persons with low incomes ranging from below to just above the poverty level. About 28% of those without insurance had incomes

below the poverty threshold, and a like number had incomes between 100% and 200% of poverty. Many work for small employers in service trades in jobs characterized by low wages, less than full-time employment, and high turnover. Insurance coverage is less frequently offered, and where it is available, employers often do not include dependent coverage nor, where it is available, contribute to its costs. Insurance coverage among employees of small firms is estimated to average 50%. Of an estimated 5 million uninsured children and spouses (or about 15% of all uninsured) who live with an insured head of household, it is likely that most are in these small employer, low-wage jobs. In addition to a high frequency of uninsurance, many of these people appear to be underinsured; one analysis of underinsurance estimated that about 43% of insured part-time workers and 56% of the insured self-employed had no limit on out-of-pocket expenses.

Two relatively small employment-related groups that appear to often lack health insurance protection are the working disabled and early retirees. The working disabled are often excluded from workplace coverage by preexisting condition clauses, and those commercial insurers willing to cover them charge very high premiums. Similarly, many early retirees, while they have enough income that they are above the poverty level, cannot afford high non-group premiums. Some of them have chronic medical problems that do not meet the criteria that would qualify them for publicly-financed health insurance, yet they are not old enough to be covered by Medicare.

Because of relatively broad coverage decisions made by some states, some of these low-income workers and others will qualify for Medicaid or state-financed programs. The Department of Labor estimates that some 1.6 million retirees under age 65 and 1 million of their dependents have continued employment-based insurance. A handful of the working disabled will be covered by Medicare under so-called 1619(b) eligibility. Notwithstanding these spotty coverages and the fact that most will face relatively small out-of-pocket health costs (300 to 400 dollars in 1980), these are clearly families that are quite vulnerable to the impact of uninsured health services costs.

In addition to looking at a snapshot of insurance coverage, it is

important to evaluate the nature and direction of changes in health insurance protection. For example, we have already recognized that there is considerable lack of insurance among small employers. What role can and should be played by small employer groups -- associations, insurance-buying cooperatives, so-called multiple employer trusts -- and how can the government encourage experimentation? Until now, there have been few such arrangements, and not all have been successful. One that deserves closer examination is the Cleveland Organization of Smaller Enterprises (or COSE), an arm of the Cleveland Chamber of Commerce. COSE has aggregated 4,500 employers with 45,000 employees and their 55,000 dependents into an insurance-buying cooperative. Forty percent of COSE's members have fewer than 10 employees, and seventy-five percent have less than 25 employees.

A second example of change is the willingness of insurers to experiment with new insurance products. For example, in 1981 Blue Cross of northeast Ohio offered laid-off workers and their families a plan with a hospital deductible of $1,500 and a medical/surgical deductible of $1,000 at a cost of $50 per month. While only 123 people enrolled and the plan was abandoned, this kind of exploration of new products must be continued. Blue Cross and Blue Shield of Western Pennsylvania has also tried some new "products:" in 1985, they had 8,000 subscribers (up to 20,000 people) for a special program for the recently unemployed. The program entailed some subsidies and has since been altered, but is another example of a willingness to innovate. Another initiative by the Western Pennsylvania "Blues" has been to develop a special insurance plan for children from families with incomes below $12,000 per year. Private charities or service organizations and the Pennsylvania State government all play some role. At a premium of only $13 per month, services are limited but focused on those services children are most likely to need. We need to ask ourselves what is restraining further experimentation, and how those barriers can be removed.

A third example of change is the role of state governments in forming health insurance pools. Such pools are often targeted on persons with chronic health problems who are unable to obtain group or private coverage although they can be made broadly available to any individual and even to groups. They usually entail subsidies by states' taxpayers or by commercial insurers operating in the state. The pioneering work of Connecticut, and

the operation of pools in Minnesota, North Dakota, Indiana, Florida and Wisconsin offer a strong base of information for other states to draw upon in trying out models that will fit their particular circumstances. And recent legislative actions by Iowa, Nebraska, Montana and Tennessee are, I believe, the beginning of broadened and increasingly innovative state involvement in this area.

A final example of change is the limited and targeted action taken by the Federal government to safeguard selected populations. Here, I refer especially to COBRA's provisions broadening protection for persons who lose their insurance coverage when they become unemployed, and for widows and divorced persons and their dependents who lose employment-related protections.

FAMILIES WITHOUT A LABOR FORCE AFFILIATION

Some families do not have an attachment to the labor force through which they can obtain health insurance protection. Some have never had private, group health insurance; in other cases, long-term unemployment (including workers displaced by major industrial shifts) or disability or retirement has outlasted whatever employment-based health insurance they might have previously had. One alternative for such persons is to purchase individual policies; but pre-existing conditions often limit insurability, and the premiums are seldom affordable. Publicly-financed insurance and services programs form the core of coverage for this population which can be divided into two major groups -- those categorically eligible for Medicaid, and the medically indigent.

Approximately 22 million of the poor are categorically eligible for public cash assistance, hence eligible for Medicaid: these include some 3 million blind and disabled (including some early retirees), 3 million poor elderly, and about 16 million dependent children and adults in single-parent families. For these categorically eligible persons, Medicaid has largely solved the problem of access.

But Medicaid also affords backup insurance for thousands of more

Americans. Medicaid participation is traditionally counted in terms of persons actually enrolled or actually receiving Medicaid-financed services; however, Medicaid is available for many additional categorically-eligible persons who are not counted until they use health care services and are only then registered into the program. The most prominant example of this are low-income persons in the 31 states with a Medicaid spend-down program; the program is prepared to support them if medical bills cause them to spend down into actual eligibility. A second example is the 24 state programs for intact families with an unemployed parent; only when such families incur medical bills that they are unable to pay are they counted as Medicaid-assisted. As one illustration of this underestimate of Medicaid protection, Florida estimated that some 51,000 persons would be eligible for assistance under their expanded Medicaid eligibility; to date, only some 3,000 have actually received assistance. This suggests that Florida Medicaid stands ready to help some 48,000 persons who have not yet sought assistance.

Some people point to the Medicaid program as an example of underinsurance citing the wide variation in the number and type of optional services the states choose to provide, or the restriction of certain services only to categorically eligible persons and not to the medically needy, or limitations on the amount, duration, or scope of covered services for which they will pay. These limitations are entirely real and are often a source of problems for the poor in obtaining the range of services they need. However, these limitations are at least partially offset by other considerations. Some states are very flexible in paying for non-covered services using the latitude afforded by the term "medical necessity." Other states use state-financed programs to "wrap around" Medicaid and finance additional services. Services are also available through local public providers and as charity care (in some cases carried out to meet Hill-Burton obligations).

In addition, Medicaid policies help to protect categorically eligible families against very large out-of-pocket costs. The first protection is through requirements that any cost-sharing imposed by states not be applied to certain services at all, and where they are applied, they must be nominal. The second is through the so-called "deeming" rules which protect beneficiaries' families from being financially ruined by high

costs usually associated with extended stays in health care institutions.

The net effect of the generally broad coverage and the cost-sharing limitations on Medicaid families' out-of-pocket expenditures was measured by the National Medical Care Utilization and Expenditure Survey conducted in 1980. Analysis of that data for multiple-person families insured by Medicaid where all members are under age 65 indicates that mean out-of-pocket spending at the 90th percentile -- that is by high cost users of care -- was approximately 250 dollars per year. In sum, while there are gaps and limits to be faced by Medicaid beneficiaries, the services to most recipients are comprehensive and meet their needs.

In the Medicaid program as in other areas of health insurance, coverage is expanding. In 1985, 28 states expanded eligibility (12 of them to incorporate DEFRA-mandated children and pregnant women). 26 states expanded covered services. In addition, movement toward improved cost controls is likely to free up funds for further selective program enhancements.

In addition to Federal sharing of the costs of Medicaid coverage, the Federal government provides direct support to others who might be counted as uninsured -- approximately one million American Indians and some 500,000 seasonal and migrant farm workers.

The poor who lack private insurance yet are not categorically eligible for Medicaid are frequently referred to as the medically indigent. There are no consensus estimates of the size of that population group. While the medically indigent are likely to be counted as uninsured, they are not without access to care. State and county governments are fulfilling their historical and legal obligations by providing general medical assistance financing programs and public hospital and clinic services programs which are available at little or no direct cost. Estimates of the value of state and local contributions range upward from $2.5 billion. In addition, Federally-supported programs provide direct and effective services to many of the uninsured poor: for example, National Health Service Corps workers provide care to over 3 million persons, many too poor to pay; Community Health

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Centers serve over 5 million persons; and state and local governments make flexible and effective use of Federal health block grant funds (including, for example, some 400 million dollars for maternal and child health). Are the people assisted through the programs described above uninsured? Yes, surveys will count them as uninsured. But are they unprotected or without access to health services? No.

Because of the special interest of this Committee, I want to return for a moment to one categorical group -- the elderly. For persons over age 65, the problem is not one of uninsurance but of instances of incomplete coverage. Ninety-seven percent of all persons over age 65 are covered by Medicare. About 2/3 of these persons are also covered by some form of private insurance and an additional 13% -- the elderly poor -- are covered by Medicaid.

Analysis of Medicare part A data indicates that some 75% of aged beneficiaries have no Part A out-of-pocket cost-sharing, about 20% have cost-sharing of between 1 and 500 dollars, and less than 1% (about 220,000 persons) have cost sharing greater than 1,000 dollars. In part B, beyond the premium, one-third of beneficiaries have no cost-sharing, 43% have less than 500 dollars, and about 6% (about 1.6 million persons) have cost-sharing in excess of 1,000 dollars. However, it is important to be clear that these are estimates of amounts the Medicare program does not pay; there needs to be subtracted from these estimates amounts that are paid by employment-based retirement insurance, by "medigap" policies, by the Medicaid program, and by other third-party insurance.

Although we do not have Medicare program data to make an estimate of beneficiaries' net out-of-pocket obligations, some indication is available from the National Medicare Care Utilization and Expenditure Survey of 1980. That survey found that for one-person families age 65 and over, average out-of-pocket costs were 512 dollars where the person had Medicare insurance only, 428 dollars where the person had Medicare and other private insurance, and only 184 dollars with Medicare and other public program protection (presumably Medicaid). If we look at persons at the high end of the spending distributions -- that is at the 90th percentile -- the analogous amounts were 1,472 dollars for

Medicare only, 867 dollars for Medicare plus private insurance, and 492 dollars for Medicare and other public insurance.

Thus, nearly all elderly are broadly insured and cost-sharing for most Medicare beneficiaries is quite limited and generally within reach of their incomes. For the small proportion of beneficiaries whose expenses do exceed their ability to pay, however, the President proposed in 1983 to improve protection through the "Medicare Catastrophic Hospital Cost Protection Act." At the President's instruction, we are again actively exploring protection against catastrophic costs for the elderly and all Americans.

With respect to long-term care, 70% of such care is provided informally with institutional care costs paid in equal parts by the elderly themselves and through the Medicaid program. Demographic trends are certain to put increased pressure on this pattern of financing, and we are looking closely at alternatives as part of the catastrophic insurance project. While the private long-term care insurance market is in its infancy, there is an increasingly positive attitude regarding the feasibility of developing a market for it. We need to look carefully at means for reducing barriers impeding its growth.

Mr. Chairman, in conclusion let me summarize my key points. First, I believe that we need to be very cautious about accepting either the aggregate numbers of uninsured and underinsured or what passes for conventional wisdom regarding their interpretation. Second, even for those without broad, full-time, third-party health insurance, there is a network of health financing and services that is extensive, available, and functioning with considerable effectiveness. Third, improvements are occuring; they do not constitute a revolution in health insurance, and they affect a relatively small number of people, but they are clear signs of a healthy evolution of expansion and enrichment in health insurance. They challenge us to be cautious in our generalizations and alert to opportunities to encourage and promote innovation. And finally, we share with the Congress concern over individual experiences of family economic hardship attributable to unaffordable health care costs, and believe that there are a number areas where improvements must be aggressively explored including early retirees, the low-income working uninsured and their dependents, and the availability of protection against catastrophic medical expenses.

Mr. Chairman, this concludes my formal presentation. I will be pleased to answer any questions you or other members of the Committee may have.

The CHAIRMAN. Thank you, Dr. Helms.
Dr. Reinhardt.

STATEMENT OF UWE E. REINHARDT, PH.D., JAMES MADISON PROFESSOR OF POLITICAL ECONOMY, WOODROW WILSON SCHOOL OF PUBLIC AND INTERNATIONAL AFFAIRS, PRINCETON UNIVERSITY

Dr. REINHARDT. Thank you, Mr. Chairman.

I would like to express my thanks to you and to the members of your committee for inviting me to testify on the tragic issue before this committee today; that is, the plight of the Nation's poor who lack adequate health insurance. I find this issue tragic in two ways: First, lack of adequate insurance coverage can visit intolerable and undeserved hardship on poor individuals who are victims of serious illness. That is a tragedy in its own right. But second, this Nation's apparent unwillingness to relieve poor fellow citizens afflicted with serious illness from fiscal hardship is a disgraceful stain on a society that is so admirable in many other ways. As one who has come to love this country as a naturalized citizen and views it as a privilege to live and work here, I view the persistence of that stain as tragic as well.

Mr. Chairman, I congratulate you and your committee for holding these important hearings, and I also would like to congratulate you personally for the imagination, the boldness, and the moral statement you make with H.R. 5070.

While one may wonder about the fate of H.R. 5070 in the political and moral climate of the mid-eighties, nevertheless I consider it significant and a welcome change that someone in your position has the courage to make the moral statement that bill implies.

I have a written statement entitled "Rationing the Nation's Health Care Surplus: A Paradox or as American as Apple Pie?"

I have an additional statement which I happen to have made for other purposes which I would like to submit to this committee as well. In that statement I show that, as the plight of the uninsured Americans has become ever more severe, and as we flush them out of the health care system, we have actually showered ever more money in real purchasing-power terms on our health care sector. In terms of the transfer of real purchasing powers to the providers of health care, the cost explosion in health care actually started only after 1980 and not before. To be sure, the volume of both hospital days and physician visits used has decreased since the late 1970's, but the price of health services have risen more than enough to offset the decline in volume. Total expenditures in health care are by no means under control yet.

The reason I chose the seemingly ridiculous title, "Rationing the Nation's Health Care Surplus," for my formal statement is that this title describes quite accurately what is actually transpiring in this Nation.

We have a surplus of doctors and of hospital beds. We spend more money on health care than any other nation or than we ever did historically, and yet from time to time we deny suffering fellow Americans access to these resources just because they are poor and uninsured.

I quote in my statement from the Wall Street Journal, which is a daily not known for knee-jerk liberalism:

> A 32-year-old accident victim lies unconscious in a Florida hospital that has no neurosurgeon available, but two larger hospitals with neurosurgeons refuse to accept him upon learning that there is no guarantee his bill will be paid.
>
> A pediatrician in a Rock Hill, SC hospital wants to transfer a comatose 3-year-old girl to a better equipped urban medical center, but her family has no health insurance, and two hospitals refuse to take her in. A hospital 100 miles away finally accepts her.

It is important that Americans realize that this denial of surplus resources to patients who are poor and uninsured is a uniquely American phenomenon. It is simply inconceivable that a 3-year-old comatose girl needing health care would be denied access to available health-care resources in Canada, in France, in Germany, in Sweden, or anywhere else in the civilized world.

Why does this phenomenon occur in a country whose President makes it a point regularly to proclaim to the world that we Americans are the most generous people on Earth and in the history of mankind? That is a question that should vex all of us.

The source of the problem lies in the fact that, at any point in time, there are some 35 million Americans who lack health insurance coverage. It is, of course, true that not all uninsured Americans get sick every year and that not all sick uninsured Americans are denied care. But one thing is sure: If one is uninsured and sick and poor in this country, and if one does receive health care, one receive it in the status of a health care beggar. In my subjective judgment, that is not a dignified posture, particularly at a time when one is anxious and suffering pain.

Canada, France, Germany, Italy—every other country in the civilized world—provides its citizens with the dignity of accessing health care without having to beg for it. I think this Nation at some point must find it in its heart to bestow on its citizens the same dignity. We could easily afford it from a macro-economic standpoint. The issue is purely an economic one.

It has been mentioned by Dr. Helms, and it is true, that we proceed considerably on anecdotes when we discuss the plight of the uninsured. The only reliable study I know is a Robert Wood Johnson study of 1982, which led to the conclusion that 1 million families in America were denied care for want of ability to pay in that year.

Many of my colleagues, particularly in the economics profession, argue that 1 million among 250 million is really not a lot. I would say you have to have the right denominator to make a sensible assessment of this statistic. We should think of 1 million persons among uninsured poor who were also sick in 1982. As a proportion of sick, uninsured, and poor Americans, I million is no longer a trivial number.

I find it puzzling that the Department of Health and Human Services tries to soothe us with the thought that we really do not know the exact dimension of the problem and yet does so little to monitor the problem on an ongoing basis. The DHHS is still working with a 1977 data base. If I was the Secretary of DHHS, the first thing I would do would be to implement a policy under which this problem would be monitored on an ongoing basis. That might cost

as much as $1 million a year, but it would be a small fee to pay to remain in the club of civilized nations.

What policy options do we have to deal with this problem? Having observed the policy process in this Nation for two decades, I have observed that, as a people, we have a propensity to espouse and proclaim civic virtues which we are much too chintzy to underwrite financially. It is this proclivity that has been so dangerous to the health of the poor.

We are the most undertaxed nation in the industrialized world, as George Will, the conservative columnist always points out. We have the lowest tax rate as a percent of GNP for all levels of government in the industrialized world, with the exception of Japan. No country runs itself with as low a social overhead as we do. With the exception of Japan, most other industrial nations tax over 40 percent of the GNP, while we tax at 33 percent. At 33 percent of GNP we cannot do that any longer. Indeed, the deficit should have taught us that.

There is yet another feature of this Nation that seems to be uniquely ours. As a people we have an almost touching habit of confusing dreams with reality, a tendency we have developed to a fine art in the eighties. In seeking to fashion a viable health policy, we have to deal with these propensities: Our reluctance to share, and our propensity to daydream.

When policy is implanted in a cultural soil, it is like planting a flower. What is the cultural soil in which the policy would have to be implanted, and what is the mechanism, the political process by which we must do the planting?

It is my sense Americans always claim that they are the egalitarian society. Having had either the misfortune or privilege of having been apprenticed in social ethics in two other societies—Canada and West Germany—I would say the notion that America is an egalitarian society is ludicrous. Just walk through Toronto and through any American city, and you will see immediately how silly the American affliction really is: We are by no stretch of the imagination an egalitarian society.

We have a two-tier society in almost all human services. In education, we tolerate enormous tiering. In the system of jurisprudence, we have a two-tier system. It would be surprising to me if we could ever graft on our society a one-tier health system.

I hasten to add that no other country has one-tier health care either, as one might understand it in the extreme. Other countries have a one-tier system for the bottom 90 percent of the population, and another for the top 5 percent.

I believe that we have to think two-tier health care for America as a realistic proposition, because that is what the social ethics of this country really emply. It is daydreaming to think that we truly wish an egalitarian system.

Let me now come to the political process by which we would plant our health-policy flower into the multi-tier social ethic, its soil. Mao Tse Tung said political power grows out of the barrel of a gun. That is not true in this country. Here political power grows to a considerable degree out of the purse. I draw from this premise the implication that any national health legislation that would im-

poverish the moneyed interest groups in health care doesn't have much of a chance to survive to passage.

Therefore, I propose in my formal statement an alternative system, which is not particularly flattering and may not be well liked at the level of political rheteric. It is a two-tier system, a national health insurance program for the poor only—say, the bottom 20 percent of the income distribution, leaving 80 percent to the private insurance industry.

The system would be Federal. The reason I make it Federal rests in the widely shared belief that this is a Nation and not just a place. It is a Nation, then I, in New Jersey, clearly should be concerned with what is or is not done for an American infant in Arkansas or Arizona, and vice versa. But if I so worry, then I can express that worry only through a Federal institution—hence a Federal program.

My proposal basically would be roughly as follows: Every American resident is ipso facto insured for a basic comprehensive package, as comprehensive as the one in H.R. 5070. The program would be financed with Federal taxes—on the 1040 tax form would be a line calling for a health insurance tax, say, 12 percent of adjusted gross income. If, however, the taxpayer has a superior private policy, they clip a copy of the policy to the 1040 and need not pay 12 percent of adjustable gross income. Instead they would pay, say, 1 percent of adjusted gross income as a down-payment for the Judeo-Christan ethic or whatever language one might use there. It would be an earmarked health care tax to cover the poor.

Now, if we had—5 to 20 percent of the people in this plan, we might be talking about $60 billion to $80 billion of Federal dollars to pay for the program. Much of that money could be had by closing the last remaining loophole in the Tax Code: the exemption of fringe benefits from taxation.

If fringe benefits were taxed, we might have some additional $30 billion to $40 billion Federal revenues right now.

One might think of asking the aged to play some noblesse oblige among themselves and vis-a-vis the baby boom, and fold Medicare into the scheme. The aged who are well-to-do, would than have to pay a higher premium for the package. We might get an additional $10 or $20 billion in Federal revenue from that source. The remainder should be a tax increase.

When I talk about tax increases, I could be accused in this day and age of having mental deficiencies, because we have a large Federal deficit already, I would submit, however, with all due respect that this deficit is self-induced. It is based on a very foolish populist Keynesianism that had been sold to a gullible electorate as "supply side economics," but was, in fact, ever so much more thoughtless and reckless than old-fashioned Keynesianism had ever been. The notion you can cut taxes and increase Federal expenditures all the while balancing the Federal budget by 1984 was so absurd, even in 1981, that very few respectable economists supported it. You had to be something of a guru to do that and take leave of your senses, to believe in the notion. But don't take my word for it—the official Federal budget numbers clearly show the foolishness of the policy.

I believe that Congress will within the next half decade come to its senses and raise taxes quite substantially. In the process an earmarked tax of the nature I am talking about should not be difficult to legislate.

I would like to end this testimony on a personal note.

Last week on the occasion of my mother's 75th birthday, my family and I traveled to Europe. We flew into Luxembourg and literally the first thing we did upon getting off the plane was to visit the large American military cemetery in Luxembourg. It is an emotional experience that makes one at once proud of this country and cry at the same time.

My wife, who is Chinese, and I routinely take our children to American military cemeteries so that they should learn to honor and respect the Americans who walked so tall when they lived and sacrificed their lives for so noble a cause, and for no personal profit at all.

As I stood there among these thousands of graves, crosses or Stars of David, I could not help but think about these hearings that I was scheduled to attend today, and about the social problem it addresses. Inevitably I was led to contrast the soul and the spirit of the generation of Americans who liberated Europe and the Far East in World War II with the petty narcissism, with the timidity and with the social pathos that defines our society today.

We are a nation, as I mentioned, that now indulges itself in a mindless Keynesan consumption boom financed by borrowing over $100 billion a year from our former enemies. We stand impotently before the self-inflicted deficit that is part and parcel of this consumption boom, and we seek to reduce that deficit by denying care and generous financial assistance to American families struck by illness.

The question I asked my children in Luxemburg and that I would like to ask you today is this: what has happened to the spirit and the soul of this once so grand people? And, will we ever again be able to rise above the pathetic narcissism of the 1980's?

I leave you with this queston, and I thank you for trying to address it with H.R. 5070 with the dialog of these hearings.

The CHAIRMAN. Thank you, Mr. Reinhardt.

[The prepared statements of Dr. Reinhardt follows:]

PREPARED STATEMENT OF UWE E. REINHARDT, PH.D., JAMES MADISON PROFESSOR OF POLITICAL ECONOMY, WOODROW WILSON SCHOOL OF PUBLIC AND INTERNATIONAL AFFAIRS, PRINCETON UNIVERSITY, PRINCETON, NJ

RATIONING THE NATION'S HEALTH-CARE SURPLUS: A PARADOX? OR AS AMERICAN AS APPLE PIE?

My name is Uwe E. Reinhardt. I am James Madison Professor of Political Economy at Princeton University's Woodrow Wilson School of Public and International Affairs. Much of my professional activity is devoted to research in health economics and health policy.

I would like to thank you, Congressman Roybal, and the members of your Committee, for inviting me to testify on the tragic issue before this committee today: the plight of this nation's poor who lack adequate health-insurance. The issue is tragic in two ways. First, lack of adequate insurance coverage can visit intolerable and undeserved financial hardship on poor individuals who are victims of serious illness. Application of the word "tragedy" to such situations is not hysterical. But, second, this nation's apparent unwillingness to relieve poor fellow citizens afflicted with serious illness from fiscal hardship is a disgraceful stain on a society that is so admirable in many other ways. As one who has come to love this country as a naturalized citizen and views it as a privilege to live and work here, I view the persistence of that stain as tragic as well. In that spirit, I congratulate and thank your Committee for holding these important hearings.

I. THE DENIAL OF SURPLUS RESOURCES: SOME ILLUSTRATIONS

In its issue of March 8, 1985 The Wall Street Journal, a newspaper not known for left-wing hysteria, reported the following incidents under the headline "Hospitals in Cost Squeeze 'Dump' More Patients Who Can't Pay Bills."

> A 32-year old accident victim lies unconscious in a Florida hospital that has no neurosurgeon available. But two larger hospitals with neurosurgeons refuse to accept him upon learning that there is no guarantee his bill will be paid.
>
> A pediatrician in a Rock Hill, S.C. hospital wants to transfer a comatose three-year old girl to a better equipped urban medical center. But her family has no health insurance, and two hospitals refuse to take her in. A hospital 100 miles away finally accepts her.

On February 18, 1985 BUSINESS WEEK, a weekly not known for left wing hysteria either, reported that

> Linda Lee McCoy of Riverton, Wyo. was two months pregnant last fall when doctors told her that complications required surgery. But she and her husband, who earns $ 9,600 a year from a job at a tire service center, didn't have the $ 500 downpayment that uninsured patients need to enter Riverton Memorial

Hospital. The survey was delayed a month, until McCoy sought funds from a county program. During that time, she says, she bled internally and suffered a great deal of pain.

These are but two examples of a phenomenon that appears to become ever more common at the nether fringes of our health system: the refusal of health care to poor, uninsured individuals in the face of a surplus of doctors and hospitals.

Stories of this sort have appeared in numerous newspapers around the country. One reads in the American Medical Association's American Medical News (July 19, 1985) that, for poor American families without health insurance, the cost of having a baby can be a serious financial burden, especially if the birth involves complications. One reads in the NATIONAL JOURNAL (November 24, 1984) of a woman who was told, in mid-labor, to vacate a private hospital and go to a public hospital after she casually mentioned during labor that her husband had just lost his job which, in this country, implies that the family is automatically without health insurance. And one reads of a seriously-injured burn victim who was refused admission to a university hospital equipped with a burn center, once again because that person seemed to have no health insurance coverage. Further examples of denied care could be had, by this Committee, from representatives of the Childrens' Defense Fund, or from representatives of local legal-aid societies.

Precisely how many American families shares such agonies remains unknown. Indeed, curiously, or perhaps not, the Department of Health and Human Services does not appear to maintain a reliable, annual survey of this facet of our health system, as any government genuinely concerned about the issue should and would. In 1982, the Robert Wood Johnson Foundation estimated from such a survey that about 1 million American families in that year were denied needed health services for financial reasons. As a proportion of the entire United States population--young and old, healthy or sick--that number may appear small. As a proportion of the nation's uninsured poor, it is much larger. As a proportion of those uninsured poor who were seriously ill in that year, the number may no longer be insignificant.

It should be clearly understood by the American people and those who represent them in Congress that the denial of urgently needed health services to poor patients in the face of abundant health-care resources is a uniquely American phenomenon. It is simply inconceivable, for example, that a Canadian, French, German or Dutch three-year old comatose child would ever be denied nearby available neurosurgical services simply because that child's parents are poor and uninsured. It is similarly inconceivable in these countries that a woman would be told in mid-labor to vacate a hospital just because she lacks health-insurance coverage. And it is just as inconceivable in these countries that the usually joyous advent of a birth should visit upon a family the kind of fiscal hardship it appears to in this country. Sadly, it can be said that this happens "only in America!"

And yet Americans are in the habit of thinking of themselves as "the most generous people on earth," a postulate of which our President reminds us publicly with some regularity. Furthermore, at almost every conference on health care in this country, we tend to proclaim loudly for the world to hear that "ours is the best health system in the world." The question we must ask ourselves at this juncture in our history is whether these felicitous slogans, if they have ever been valid, remain valid today, or whether perhaps we repeat them so often and so loudly precisely because in our hearts we know them to be untrue.

An altogether healthy exercise for the American people would be to ponder this question carefully. It may be the first step towards actually attaining, at long last, those civic virtues of which we tend to pride ourselves, but which we seem much too tight-fisted to underwrite financially.

II. THE NUMBER OF UNINSURED AND UNDERINSURED

Probably the best current source of information on the number of un- and underinsured Americans is a chartbook entitled THE UNINSURED AND UNCOMPENSATED CARE, compiled by Margaret B. Sulvetta and Katherine Swartz of the Urban Institute and published in June of this year by the National Health Policy Forum of George Washington University. Unless otherwise indicated, the statistics reported below are drawn from that excellent compendium.

The Number of Uninsured

In 1983 an estimated 35 million Americans appeared to have no health insurance whatsoever at the point in time the underlying survey was made. That number represented about 17% of the U.S. population under 65 years of age. Not all of these individuals, however, were uninsured for the entire year. Earlier research had establishes that, in 1980, only about 18 million (or 9.7% of the population under age 65) were uninsured for the entire year. The remainder probably found themselves between jobs and therefore were without health insurance coverage.

While temporary unemployment usually does imply lack of health insurance, it is the case that close to two-thirds of all uninsured adults in 1984 were employed and only 12 percent were unemployed. Uninsured employed persons probably work for small business firms that find it difficult to obtain affordable group health-insurance coverage from the private health-insurance sector at affordable prices. The private health-insurance sector, in turn, finds it impossible to offer more readily affordable premiums to small business firms because of (a) the high fixed unit costs of enrolling small groups of employees and (b) the higher probability small business firms will default on premiums when they meet economic adversity.

It may further be noted that over half of the uninsured belong to families living within 1.5 times the official poverty line and over one third actually live below the poverty line. But even for families with higher incomes, health insurance coverage may not be readily available if it is not provided by an employer. The marketing of health insurance to individuals has been found to be so expensive that some commercial insurance carriers to not even offer such policies any more. Those that do

may have to charge premiums that strain the budgets of even middle-income families. In short, the imagery--preferred by some commentators--that lack of health insurance status simply reflects reckless improvidence on the part of consumer would be generally way off the mark.

Finally, about 33% of all uninsured persons are children under age 17. Surely even the most hardnosed analyst would have to view children as victims of their circumstances. Many Americans probably comfort themselves with the thought that at least the young have been well provided for through the Medicaid program. That program, however, is very spotty and uneven in its incidence. In 1980, for example, anywhere between 30 to 80 percent of the nation's children living in officially defined poverty were not covered by Medicaid (see Table 1 overleaf).

Table 2 below, taken directly from the Urban Institute compendium, presents data on the utilization of health services by insured and uninsured Americans. It is seen that, relative to the insured population, uninsured persons appeared to use only 65% as many physician visit and only 52% as many hospital days in 1977. Other indicators of utilization, dated 1982, show similar discrepancies. These data, of course, permit varied

TABLE 2

MEDICAL CARE UTILIZATION OF UNINSURED AND INSURED PERSONS

INDICATOR	INSURED	UNINSURED
Physician visits per person under age 65, 1977	3.7	2.4
Hospital patient days per 100 persons under age 65, 1977	90	47
Families who needed care, but who did not receive it, 1982	4.8%	15.0%
Families who did not see a physician in 1982	17.1%	32.9%
People without regular source of health care in 1982	9.7%	23.1%

SOURCE: Margaret B. Sulvetta and Katherine Swartz, The Uninsured and Uncompensated Care, National Health Policy Forum, Washington, D.C., June, 1986, Table 2, p.4.

interpretations. Staunch defenders of the status quo, for example, might argue that the relatively lower utilization by uninsured persons reflects their superior health status and thus a relatively lower need for health insurance. Commentators who view lack of insurance coverage as a social problem, on the other hand, will interpret the data as evidence of inadequate care. I share the latter view.

The Number of Underinsured

Counting the number of completely uninsured patients understates the true dimension of inadequate health insurance in

Table 1

PERCENTAGE OF CHILDREN LIVING IN POVERTY WHO ARE NOT COVERED BY MEDICAID, BY STATE, 1980

Alabama	61%	Montana	74%
Alaska	66%	Nebraska	77%
Arizona	Not Comparable	Nevada	71%
Arkansas	69%	New Hampshire	49%
California	39%	New Jersey	34%
Colorado	54%	New Mexico	67%
Connecticut	46%	New York	34%
Delaware	44%	North Carolina	61%
District of Columbia	26%	North Dakota	78%
Florida	66%	Ohio	43%
Georgia	57%	Oklahoma	67%
Hawaii	46%	Oregon	53%
Idaho	70%	Pennsylvania	40%
Illinois	38%	Rhode Island	39%
Indiana	66%	South Carolina	63%
Iowa	63%	South Dakota	79%
Kansas	57%	Tennessee	56%
Kentucky	67%	Texas	75%
Louisiana	59%	Utah	64%
Maine	52%	Vermont	51%
Maryland	40%	Virginia	63%
Massachusetts	28%	Washington	49%
Michigan	35%	West Virginia	57%
Minnesota	67%	Wisconsin	57%
Mississippi	54%	Wyoming	80%
Missouri	55%		

Source: Adapted with permission from *The Data Book: The Nation, States, and Cities*, 1985, p. 23, Children's Defense Fund.

CITED IN: Margaret B. Sulvetta and Katherine Swartz, The Uninsured and Uncompensated Care, National Health Policy Forum, Washington,D.C., June 1986, Table 3, p.9.

this country. Many families have health insurance policies that are so shallow as to leave them exposed to considerable financial risk in case of major illness.

Just what is meant by "considerable risk" is, of course, a matter of personal judgement. Defining "considerable risk" as a probability of 5% or more of having at least 10 percent of one's family income absorbed by out-of-pocket expenses for health care, Pamela Farley estimated from data gathered in 1977 that 23.5% of a then total U.S. population of 189 million under age 65 faced "considerable financial risk" due to lack of adequate health insurance.* For members of female-headed households the corresponding percentage was 36.1%; for poor and near-poor families it was 52.6%; for white Americans it was 21.1%, for Blacks 30% and for Hispanics 28.3%.

Ironically, for persons with an "excellent" perceived health status the percentage with inadequate health insurance was only 18.5, while that for persons with a "poor" perceived health status it was as high as 38.8. The finding is ironic, although not surprising, for in a nation that considers "actuarially fair" health insurance premiums** as the sine-qua-non of "economic efficiency," healthy persons naturally find health insurance coverage more readily accessible and affordable than do sick individuals.

III. CARING FOR THE UNINSURED

Lack of health insurance in America does not *ipso facto* imply the denial of health care in times of need. For many years this nation has muddled through with a system that ultimately did make critically needed health care available to the uninsured who were persistent enough to seek that care and who did not mind approaching the health system literally in the status of health-care beggars.

The system worked as follows: For patients covered by health insurance, physicians and hospitals were effectively given the keys to sundry insurance treasuries--including the Medicare treasury--there to scoop up whatever financial reward was "usual, customary and reasonable." Implicit in this open-ended social contract was the understanding that these providers would somehow take care of the nation's uninsured poor. After all, the cost of such indigent care could always be fully recovered from third-party payers and paying patients through a process of "cost shifting." Although much lamented at the time by the commercial insurance industry, "cost shifting" actually served as a fig leaf over what would otherwise have revealed itself to the world as a national disgrace: it kept us in the club of civilized nations.

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* Pamela Farley, "Who Are The Underinsured?" Milbank Memorial Fund Quarterly/Health and Society, Volume 63, No. 3, 1985.

** Individuals insisting on paying only actuarially fair health insurance premiums thereby signal their refusal to become their sick and poor brethrens' keepers through the mechanism of health insurance.

Eventually, the ever escalating cost of that open-ended social contract struck both government and the business community as prohibitive. Since about 1980, these payers have therefore sought to force the providers of health care into a game of financial musical chairs otherwise known as the "competitive market." The idea behind this arrangement is that doctors and hospitals should fight for their economic survival by attracting patients through whatever means might do the trick, including price concessions. In a nation that prefers arbitration through market forces to government regulation, the competitive approach to health policy obviously has a certain attraction. On the other hand, it should have been clear to anyone with a basic grasp of economics that, under the rules of a price-competitive market, the providers of health care would have little incentive to sweep off the streets the human debris of a society subjecting these providers to a game of financial musical chairs. In such a market, the cost of indigent care becomes a bother one likes to transfer to competing providers through the practice not of "cost shifting" but of "patient dumping," the practice described in the previously cited piece by The Wall Street Journal.

Under the old social contract the cost of indigent care was the hot potato passed from providers to paying patient. Under the newly emerging contract, the bodies of the uninsured poor themselves become the hot potatoes that are being dumped from provider to provider. Politicians ought not to feign surprise at this transformation, nor ought they to remind physicians of their Hippocratic Oath. Indeed, to blame doctors and hospitals for the practice of 'patient dumping' all the while refusing to legislate the means of paying for the care rendered to uninsured indigents strikes one as disingenuous.*

IV. POLICY OPTIONS

Americans have debated the issue of health insurance coverage ever since the end of World War II, only to demonstrate that, in this area at least, the fabled Yankee ingenuity has taken a long leave of absence. The nation now spends close to 11 percent of its Gross National Product (GNP) on health care, more than any other industrialized nation in the world. Yet in spite of these enormous outlays, the nation has not so far succeeded in assuring all of its citizens easily affordable and dignified access to health care, where by "dignified" is meant the procurement of health care in a status other than that of a health-care beggar who receives health care in unpredictable fashion, as an act of noblesse oblige, on the part of some kindly provider.

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* Some states, for example, have made the dumping of seriously ill patient illegal yet have failed to provide public financing for such care. It makes a thoughtful person lose respect for such legislators.

As I have argued at greater length elsewhere*, the nation's manifest impotence in this area reflects an inability to agree on the ethical precepts that ought to govern the production and distribution of health care. We have not been able to decide whether health care is intrinsically a private consumption could whose financing should be the primary responsibility of the individual patient or whether it is intrinsically a social good, like elementary education, that should be collectively financed. We have not been able to decide whether the receipt of medically feasible relief from acute pain should or should not be one of an American's basic rights. It does not appear to have been the right of Mrs. McCoy in Wyoming, for example. Finally, we have not been able to decide whether the enforcement of such rights as we may declare in health care should be a Federal or a state and local matter. Alternatively put, the question is whether a resident of, say, New Jersey should be at all concerned over what is or is not done for an American infant in Florida, and vice versa, and similarly for other states. Remarkably, this nation's answer to this question so far appears to have been: " The health care of an American infant in Florida is not really the New Jerseyan's business (and vice versa) " The answer betrays a rather peculiar conception of nationhood.

To be sure, for public consumption the nation's politicians have long allied themselves with the precepts of an egalitarian distribution of health care, as have the nation's business executives. The public at large, too, has flattered and soothed itself with the notion that ours is a one-tier health system making the best medical care in the world available to all regardless of ability to pay. But these lofty protestations have not so far been accompanied with adequate funds. In a sense, the nation's poor have been victimized by the very loftiness of our professed goals--as well, of course, by this sentimental nation's uncanny ability to confuse dreams with reality.

The design of a viable health policy for our nation must be firmly based on

a. a clear, unsentimental appreciation of this nation's social ethics, and

b. an equally unsentimental understanding of the way in which public policy is legislated and implemented

Let us examine these two facets in turn.

From the vantage point of one who has been reared in the relatively egalitarian social ethics of two other nations, the so frequently mouthed proposition that ours is an egalitarian society appears almost ludicrous. While it is true that this nation, probably more than any other, does provide healthy and well trained individuals wide opportunities to seek economic advantage, it is simply not true that such latitude amounts to

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* See U.E. Reinhardt, "Hard Choices in Health Care: A Matter of Ethics," in HEALTH CARE: How to Improve it and Pay for it, Center for National Policy, Washington, D.C., April, 1985.

"equal opportunity," certainly not for persons born into poverty and/or ill health. We do not have a one-tier judicial system, and we do not have a one-tier educational system*. Under the admissions process.
The two features make it unlikely that this nation will soon be able to implement an affordable, operable, universal national health insurance system of the sort now operating in Canada and throughout Europe. Indeed, it is not at all clear that such a system, if it could be introduced, would be in the nation's best interests, because it would require a heavy regulatory superstructure that might stifle our health sector's penchant for innovation--one of the truly admirable traits of that sector.

A more viable and potentially quite humane alternative might be something like the following:

1. As a matter of principle, every American resident should be ipso facto covered by a Federal health insurance program that covers a defined set of basic medical

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* Although the leaders of private schools and universities would may protest that access to their institutions is based strictly on academic merit, no one working within these institutions could honestly deny that family wealth and lineage act as a partial substitute for academic competence in the circumstances, it would be very surprising, indeed, if we truly aspired to a one-tier health system. Having observed this nation's health policy at close range for the better part of two decades, I am persuaded that the best this nation's poor can ever hope to attain in health care would be a two- or multi-tier system in which the poor might be guaranteed unfettered access to critically needed basic care, but in which there would be perceptible differences in at least the amenities accompanying that care, if not also in the clinical quality of that care. To an objective observer with some international experience, that sort of tiering appears as inevitably American as the proverbial Apple Pie.

The second dimension to be considered in the design of a viable health policy is, as noted, the political process by which that policy would be implemented. For better or for worse, our system of governance is one in which political power grows to a considerable degree out of the power of the purse. Given the wide coverage the media regularly give to the political power of moneyed interest groups, it is surely not impudent to suggest before this body that even the best intended health legislation has no chance of survival if it is not countenanced by the moneyed associations of health-care providers and insurers who have always dominated and fashioned American health policy. To be viable at all, any policy designed to provide health insurance coverage to the poor must put added funds into the pockets of these associations' members or, at least, it must not siphon money away from them.

A Potentially Viable Health Insurance Program for the Poor

The task at hand, then, will be to fashion a health policy that is attuned to these two particular features of our society: our manifest preference for an inegalitarian distribution of basic human services and the political power of interest groups

benefits. Persons who elect this program--and the bulk of Americans probably would not--would not necessarily enjoy the freedom of choice granted to fellow Americans who elect and can afford private health insurance. Publicly financed patients would have to accept non-emergent care from their choice of a limited number of competing Health Maintenance Organizations. Emergency care could, of course, be sought from the nearest provider.

2. The program should be Federal on the notion that a resident in, say, New Jersey should indeed be concerned over what health services are given an American infant in, say, Florida, and vice versa, and similarly for adults. Ultimate Federal responsibility for the program would not, of course, preclude active participation by states and local governments in the operation of the program (as has been found useful in most other nations as well).

3. No health care provider in the United States would ever be asked to render "needed" health services to patients without a reasonable compensation. This compensation should be negotiated ex ante with national associations of the relevant providers. It need not be equal to these providers desired customary charges, but should be high enough that no provider would actually lose economically by having treated publicly covered patients. Although the underlying fee schedules ought to be national in structure, there ought also to be adjustments for regional variations in costs.

4. This national program would be financed on the basis of ability to pay. One approach might be to include on Internal Revenue Service Form 1040 a line labelled "Health Insurance Tax--Enter X% of Adjusted Gross Income." If the taxpayer attached to Form 1040 a copy of a private health insurance policy as good or better than the public policy, then that tax payer would be excused from paying the X% tax. Instead, however, that taxpayer would be required to pay a much smaller Y% towards a fund explicitly earmarked to cover part of the cost of the public insurance program.

5. Added funding might be garnered by eliminating one of the remaining tax-shelters in the American tax code: the exclusion of fringe benefits (including employer-paid health insurance) from taxable income. Economists have long argued that this exclusion is not only economically inefficient, but horizontally inequitable as well.

Clearly this program would be a national program, but it would not be the type of National Health Insurance program operated by other nations and rejected by this country during the 1970s, after intensive debate. It would be a national health insurance program primarily for the nation's lower economic strata, and only that program would be based on ability to pay. The rest of society could continue to seek coverage in the traditional way.

One of the program's political virtues would be that it would not constitute a major inroad into the business base of the private health insurance sector. The tax rate X could be so set as to preserve that industry's role in American health care. To assume that this powerful industry could be legislated out of existence would be unrealistic.

A second virtue of the program would be that it would free the providers of health care from the increasingly vexing moral obligation to render uncompensated care. It would put added funds into their pockets. Given these providers' now tenacious defense of the Medicare program which they once fought so tenaciously,

there is reason to believe that they might have learned from the experience, and that they might now support a Federal health insurance program for the poor if it offered the prospect of additional revenue.

Indigent Care and the Federal Deficit

It must be openly conceded that the proposed program would imply a added taxation, unless one were willing to add further to the nation's already indefensibly high Federal deficit. Three observations may be registered on this point.

First, the alternative to an explicit, earmarked health insurance tax will inevitably be some other tax, albeit one carefully disguised in the hope that a [presumably] ignorant electorate will not perceive it as a tax or, if it does, will not be able to assess it ultimate incidence.

The hospital revenue pools now being legislated in some states represent hidden tax systems of this sort. They involve the government's coercive power to divert funds from Hospital A to Hospital B. Such a diversion is a tax pure and simple.

Even more dubious and economically destructive is a widely proposed hidden tax going by the name "government-mandated employer paid health insurance." Surely the imposition of such a requirement is a tax, because Citizen A is being forced to transfer funds to Citizen B. Worse still, the requirement would represent in effect a tax on employment and entrepreneurship, burdening in particular the small business firm and its potential employees -firms that have been the chief source of new jobs in the last two decades.*

It is not difficult to understand our politicians' preference for such hidden taxes in the current political climate. These government coerced transfers among private individuals achieve certain political ends without letting the transferred funds flowing through public budgets. The mechanism therefore allows politicians to raise [hidden] taxes, all the while pretending to be avid tax cutters. Furthermore, the device of hidden taxes relieves the legislators imposing them from any accountability for the forced transfers (hidden taxes). In short, such hidden taxes may be politically expedient, but their imposition does not strike one as an honorable form of governance nor, in fact, as an economically efficient one.

A second observation on the nation's current opposition to tax increases is a reminder that ours is actually one of the least taxed nations in the industrialized world, as is shown in Figure 1 overleaf and in the more detailed table on which that diagram is based. Before the decade is over this nation will have discovered that the only politically acceptable way to bring the Federal budget into balance will be a substantial increase in taxes. Neither economic growth nor cuts in government spending will be able to carry the burden of that task by themselves.

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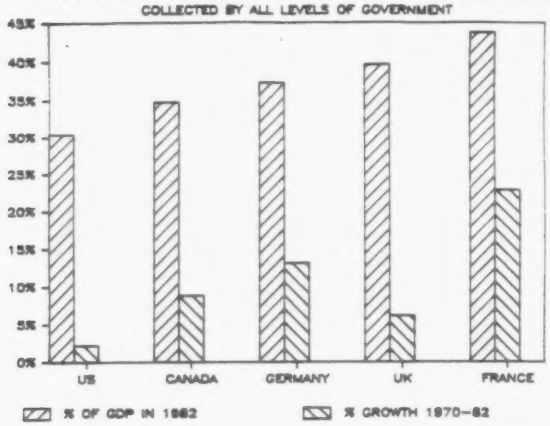
* A lenghtier examination of mandated employer-financed health insurance is offered in U.E. Reinhardt, "Should all Employers be Required by Law to Provide Basic Health Insurance Coverage for their Employees and Dependent?" (mimeographed), April, 1986.

FIGURE 1

TAX REVENUES AS A PERCENT OF GDP

COLLECTED BY ALL LEVELS OF GOVERNMENT



SOURCE: Tax Foundation, Inc., FACTS AND FIGURES ON GOVERNMENT FINANCE, 23rd. edition, 1986; Table A33 , p. a36.

The diagram indicates (a) that the United States tax burden as a percentage of Gross Domestic Product (GDP) is low by international standards and (b) that this burden did not grow very much att all during the period 1970–82, contrary to public belief.

The complete table A33 follows.

SECTION A

A33. Tax Revenues in Relation to Gross Domestic Product in Selected Countries*

Selected Years 1960-1982*

Country	Taxes as a percent of gross domestic product										Per capita taxes
	1960	1970	1975	1976	1977	1978	1979	1980	1981	1982	1982*
Australia	23 5	25 32	29 02	29 56	29 58	28 68	29 26	30 30	31 06	30 97	$3,392
Austria	30 5	35 72	38.69	38 56	39 19	41 53	41 22	41 33	42 57	41 08	3,629
Belgium	26 5	35 75	41 82	42 36	43 93	45 11	45 63	44 72	45 28	46 65	5,990
Canada	26 2	32 00	32 93	32 51	31 80	31 49	31 42	32 71	34 67	34 85	4,304
Denmark	25 4	48 38	41 35	41 55	41 89	43 42	44 49	45 68	45 03	43 97	6,244
Finland	27 7	32 24	36 21	39 97	39 58	36 43	34 97	35 27	36 04	36 60	3,778
France	n.a.	35 58	37 46	39 36	39 42	39 58	41 13	42 54	42 71	43 72	4,379
Germany	31 3	32 93	35 96	34 37	36 02	37 74	37 49	37 77	37 38	37 23	3,985
Greece	n.a.	24 30	24 64	27 27	27 59	27 93	27 74	28 64	29 22	31 92	1,250
Ireland	22 0	31 31	32 08	35 51	34 51	33 18	33 03	35 04	37 83	39 57	2,883
Italy	26 0	27 91	28 98	30 27	30 09	31 26	30 49	33 21	37 75	38 27	2,447
Japan	18 2	19 72	21 01	21 90	22 67	24 24	24 81	25 91	26 76	27 21	2,665
Luxembourg	n.a.	38 25	36 50	38 30	41 34	42 56	39 51	40 37	39 60	37 69	6,378
Netherlands	30 1	37 93	43 55	43 20	43 97	44 58	44 98	45 74	45 04	45 47	6,372
New Zealand	27 3	26 88	29 57	29 45	32 26	30 84	30 71	31 03	32 31	31 63	2,557
Norway	31 2	39 19	44 87	46 16	47 20	46 53	45 66	47 05	48 63	47 77	6,580
Portugal	16 3	23 12	24 79	26 91	27 39	26 45	26 10	29 27	31 51	30 82	721
Spain	n.a.	17 22	19 60	19 61	21 54	22 88	23 64	24 11	25 01	25 33	1,210
Sweden	27 3	40 23	43 88	48 19	50 46	50 87	49 54	49 36	51 21	50 26	5,984
Switzerland	21 3	23 81	29 61	31 30	31 63	31 58	31 08	30 78	30 56	30 93	4,618
Turkey	n.a.	17 66	20 73	21 06	21 65	21 26	20 80	19 08	20 43	20 11	228
United Kingdom	28 5	37 30	35 74	35 30	35 04	33 68	33 27	35 95	37 08	39 60	3,375
United States	26 9	29 79	29 63	28 92	28 05	29 03	29 01	30 35	30 77	30 46	3,978

* Tax revenues collected by all levels of government, recorded on a cash basis.
* Primarily calendar years, however, data from some countries recorded on a fiscal year basis.
* In U.S. dollars.
Source: Organization for Economic Cooperation and Development

To underscore the futility of placing one's hopes on future cuts in spending, one merely need to cite this nation's current policy towards its agricultural sector. In its issue of June 17, 1986, The Wall Street Journal observed

PAYING THE BILL
NEW FARM BILL RAISES
FEDERAL COSTS AND FAILS
TO SOLVE BIG PROBLEMS

It will shower Federal Money
On Prosperous Farmers
and Maintain Surpluses

In their usually acerbic editorials, the editors of the JOURNAL tend to blame such spending on the venality of members of Congress (see the editorial dated August 11, 1986, Attachment A hereto). Curiously, these editors have kindly overlooked a front-page story in August 13 issue of THE NEW YORK TIMES (Attachment B hereto) in which our President is depicted standing next to a fourteen-year old farmer and a cow, unabashedly claiming credit for having committed record amounts of Federal assistance to farmers, and reminding his audience that the $ 26 billion spent on the farm program this year was more than any previous Administration spent on the program during its tenure. (By way of contrast, the Federal government spent only $21.9 billion on Medicaid in 1985.)

If even this ostensibly budget-conscious President takes pride in spending billions of Federal dollars on a program that enriches already well-to-do farmers, that pays farmers for not growing food, that uses tax moneys to store billions of pounds of unwanted cheese and butter and millions of tons of unwanted grain in government warehouses, and that charges American taxpayers a levy of $15 per ton for every ton of grain sold at this subsidy to the so-called "Evil Empire," the Soviet Union--all for the sake of a few votes in the farm belt, then surely it would be reckless to expect that the Federal deficit will effectively be reduced through future cuts in spending.

Eventually, responsible legislators will vote for the only remedy that will close the Federal budget gap: an increase in taxes. With it, perhaps, they will find it in their heart to legislate also an earmarked health-insurance tax designed to alleviate for good the plight of poor fellow Americans (and their children) who cannot afford to pay directly or through health-insurance premiums for the marvelous services our health-care sector could, in principle, offer them. We shall then be able once more to hold our heads up high at international conferences on health policy.

Attachment A

REVIEW & OUTLOOK

How They Do It

By now the general public is probably getting the sense that Congress somehow isn't going to deliver on its promise to "cut the deficit." Nonetheless, the general drift out of the nation's capital in recent times seems to have more or less conveyed the impression that all the members are sweating on some arduous Hobbitlike crusade to slay the deficit dragon.

Fortunately the U.S. still runs an open government, and the recorded proceedings on the House floor July 31 offer a telling insight into Washington's world of deficit politics. It may be true that a majority of the House voted once for Gramm-Rudman-Hollings, which most people associate with making the deficit go down. But it's also true that the House takes many votes on spending, and as we shall see the majority more often votes to make spending go up.

The measure under consideration was the important 1987 appropriations bill for three departments—Labor, Education, and Health and Human Services. Consideration of the bill opened with a description of it by Rep. William Natcher (D., Ky.), who runs the subcommittee that sets spending for these departments. We concede that arrays of dollar figures often numb the mind, but the following compendium should prop open the eyes of anyone who wonders how Congress can do so much public grunting over the deficit and have so little progress to show for it.

First Mr. Natcher noted that the bill's total appropriation was $103,710,-[illegible],000, but that 75.5% of this was for "entitlement programs," over which Congress traditionally has said it has no control. Mr. Natcher then noted, "For discretionary programs, in which spending is controlled through the annual appropriations bill, the bill includes $24,916,647,000 in fiscal year 1987, an increase of $4,118,231,000 over the President's budget and an increase of $2,276,493,000 over the amount available for fiscal year 1986."

Of the HHS appropriation, Mr. Natcher said, "The substantial increases included in the bill reflect a number of priorities of the committee." Then he listed them. There is funding for AIDS research and for the National Institutes of Health. Also: "The bill rejects the President's proposal to terminate a number of programs. . . . The committee believes these programs should continue to be funded by the Congress. The bill reflects a decision to provide selected increases for high-priority programs. . . . The bill reflects a commitment to fund entitlement programs."

Mr. Natcher noted that the entitlements amount is $5,320,427,000 over the 1986 appropriation and added: "The President's request for these activities was based on a series of legislative and regulatory proposals not accepted by the Congress."

The catalog continued. "The bill includes $200,000,000 for the Work Incentives Program which the President's budget proposed to eliminate." The Education Department's appropriation is $13,369,231,000, "an increase of $1,458,132,000 over the President's budget request." There was more money for the Health Resources and Services Administration, whose mission "is exceptionally broad." And, "For programs authorized by the Carl D. Perkins Vocational Education Act, the bill includes $906,433,000, an increase of $505,450,000 over the budget request."

Finally, Rep. Silvio Conte, the subcommittee's ranking Republican, rose: "I am delighted to join with my good friend . . . to bring this bill before the House." Mr. Conte suggested their subcommittee's name be retitled "HELPS." He emphasized that, "Nearly 70% of this bill, or $78 billion, is in mandatory spending over which our subcommittee exerts very little discretion. We act as a conduit through which that mandatory spending passes." He criticized "Gramm-Rudman-Hollings and its miserable across-the-board cut" and said "I believe the Congress should exercise its judgment on funding for individual programs, and that's what the subcommittee did."

At length, Republican Bill Frenzel rose to point out that the committee had raised the bill's appropriation 13.5% when inflation is under 3%. The discretionary part, he noted, is up 9%. House Minority Leader Bob Michel said, "It is ridiculous that when we are seeking to meet our responsibilities under Gramm-Rudman, we should have a bill . . . nearly four times the rate of inflation."

Mr. Michel proposed amending the bill to hold its discretionary increase to 3%. Then Bill Frenzel proposed freezing its spending at the 1986 level. A period of time was then spent denouncing the Michel and Frenzel proposals. Rep. George Miller (D., Calif.) called them "a wholesale attack on the American family." Finally the House voted.

First the Frenzel amendment lost 321 to 99. Then the Michel amendment went down, 253-164. And then the House approved all the spending increases by a vote of 328 to 86.

* * *

As readers of this page know, we have editorialized for some time that Washington will never gain control over its compulsion to spend until the president has a line-item veto authority over congressional appropriations. Would someone run by us one more time why this is such a bad idea?

DRAFT
8/23/'86

HOW "MONEY ILLUSION" MAY HAVE SAVED THE AMERICAN HEALTH SECTOR FROM STARVATION (so far)

Uwe E. Reinhardt
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Woodrow Wilson School of Public and International Affairs
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"Spending for Health Care in 1985 Rose at Lowest Rate in 2 Decades," reported the New York Times in a headline on July 30, 1986. The American Medical News used literally the same headline in its issue of August 15, 1986. Both newspapers probably were inspired by language in a press release issued by the Department of Health and Human Services (DHHS) on July 29, 1986. Indeed, the tone of these headlines--that inflation in health care has abated at long last-- echoes former DHHS Secretary Margaret Heckler's proclamation in July 1984 that the "Reagan Administration had broken the back of the health care inflation monster."

Prominent members of the business community seem fully persuaded by these assertions. In a recent address to Houston's Forum Club, for example, Karl D. Bays, Chairman of Baxter Travenol Laboratories, Inc., stated that "[health-care] costs are coming under control" and that "quality" now emerges as the major issue in health care. The same theme was struck by Robert A. Schoellhorn, Chairman of Abbott Laboratories, in a published address given to the 28th Annual Meeting of the Pharmaceutical Manufacturer's Association in April of 1986. Using imagery reminiscent of a Superman or Rambo, Mr. Schoellhorn told his audience that "Ronald Reagan took the health care supertanker and turned it on a dime."[1]

Economics is known as the "dismal science," perhaps so because economists are in the habit of throwing cold water on persons given to sweet reveries. In the present instance, the reveries cited above reflect a human weakness economists diagnose as "money illusion," that is, a failure to adjust dollar denominated time series properly for inflation. Unfortunately, once that adjustment has been made the data since 1975 warrant the following set of somber conclusions:

- HEALTH-CARE EXPENDITURES EXPRESSED IN CONSTANT DOLLARS ROSE MORE RAPIDLY AFTER 1980 THAN THEY DID IN THE LATER 1970s.
- RELATIVE TO THE OVERALL CONSUMER PRICE INDEX, THE PRICES OF HEALTH SERVICES ROSE MUCH MORE RAPIDLY AFTER 1980 THAN THEY DID IN THE LATE 1970s.
- IN SHORT, IF IT IS LEGITIMATE TO SPEAK OF AN AMERICAN "HEALTH-CARE COST CRISIS," THAT CRISIS HAS TAKEN ON MOMENTUM SINCE 1980 AND IT HAS BY NO MEANS BEEN LICKED.

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[1] Focus on Innovation: The Pharmaceutical Industry in 1986, published by the Pharmaceutical Manufacturers Association; p. 22.

3

Attached hereto is a series of diagrams supporting these assertions. These diagrams are based on data published by the Department of Health and Human Services along with its press release of July 29, 1986, on macro-economic data published in the Economic Report of the President, transmitted to Congress in February of 1986, and on data published by the U.S. Bureau of Labor Statistics in its monthly updates on inflation. Each of the diagrams is annotated at the bottom. The graphs therefore require no further amplification.

Of particular interest to the busy reader will be Figure 4, which illustrates with stunning clarity the difference between nominal dollar figures (unadjusted for inflation) and real dollar figures (expressed in constant 1985 dollars). It will be seen that in the late 1970s, when the nominal figures were growing at ever larger annual rates, the corresponding real figures were actually growing at successively declining growth rates. Exactly the opposite has occured since 1980. The nominal figures have risen since that time at ever falling annual growth rates--the phenomenon celebrated in the press release--while for the most part the annual growth rates in real health expenditures have been rising since 1980.

Also of special interest to busy readers will be Figure 8. That graph shows the ratio of annual inflation in the Medical-Care Price Index to annual inflation in the Overall Consumer Price Index. During the late 1970s, the ratio fluctuated around 1, actually falling below 1 during 1978-80. Since 1980, however, the ratio has risen much above 1. It reached 2.8 in 1982-83, fell in 1983-84 to 1.6, but has since shot up again to about 3 (and much higher still if one includes oil in the Overall Consumer Price Index). Price inflation in health care actually took off only after 1980! Figure 12 shows that the momentum may even be picking up steam this year.

If these data do represent merely the false peace of mind that comes with "money illusion," then the American health care sector may be in for a hard time as both government officials and the business community awake from their pleasant reveries. On the other hand, it is also conceivable that these officials and executives have been awake for some time, but are simply powerless vis-a-vis the folks in the white coats. We shall see in the latter half of the 1980s.

Finally, as a fortuitous aside, I found Figure 6 surprising. We have become conditioned by the media to think of the period 1976-80 as one of economic stagnation, and of the period since 1980 as one of general economic prosperity. Figure 6 indicates that, remarkably, the annual growth rates in real Gross National Product during 1976-80 were quite respectable by historical standards, while the picture since 1980 has been rather mixed. In fact, the average annual compound growth rate in real GNP during

the four-year period 1976-80 was 3.1%, while the corresponding average annual growth rate during the five-year period 1980-85 has been only 2.4%. It is not obvious why one should label the 1980s as one of great economic prosperity.

NEW YORK TIMES JULY 29, 1986

Spending for Health Care in 1985 Rose at Lowest Rate in 2 Decades

By ROBERT PEAR
Special to The New York Times

WASHINGTON, July 29 — Total spending for health care in the United States rose 8.9 percent last year, the lowest rate of increase in two decades, the Federal Government reported today.

Health care spending totaled $425 billion, or an average of $1,721 for every person in the country in 1985, the report said. Health-related activities accounted for 10.7 percent of the nation's total output of goods and services, the highest proportion of this gross national product to date, it said.

Benefit payments under the Government's two main health programs increased faster than overall health spending. Medicare payments to the elderly and disabled rose 12.2 percent, to $70.5 billion in 1985, while Medicaid payments to people with low incomes rose 9.4 percent, to $20.8 billion, according to the report by the Department of Health and Human Services.

The lower rate of increase in spending for health care was almost entirely a result of lower growth of medical prices, not to any reduction in the use of health services, the Government said. "The United States is not consuming any less health care goods and services than before, either in total or per capita," it added.

Rising at Twice the Inflation Rate

While the rate of increase waned, the price of medical care continued to rise at more than twice the overall inflation rate.

The 8.9 percent increase in health care spending last year followed increases of 9.2 percent in 1984 and 10.4 percent in 1983, 13.8 percent in 1982 and 9.7 percent in 1981, the biggest jump for a single year. Before 1981, the last year with a single-digit increase was 1975, when health care spending rose 8.3 percent, to a total of $81.9 billion. That was the year in which Congress created Medicare and Medicaid.

In July 1984, Margaret M. Heckler, then Secretary of Health and Human Services, asserted that the Reagan Administration had "broken the back of the health care inflation monster." But officials were more cautious in their assessment of the data issued today.

Dr. William L. Roper, head of the Federal Health Care Financing Administration, which runs Medicare and Medicaid, said, "We are seeing a steady reduction in the rate of growth in national health care costs as a result of slower inflation." He added, "The improved economic climate under this Administration is largely responsible for these encouraging results."

But he said there was some evidence that dollars saved as a result of hospital cost regulations were being spent on other health services, such as outpatient care and nursing home care.

Private Sees "[illegible]

toric trend, rather than the start of a new trend."

Health care accounted for only 5.9 percent of the gross national product in 1965.

The report issued today also included these details:

¶Almost half of the money spent for health in 1985 was used to pay for hospital care, at $188.7 billion, and nursing home services, at $35.2 billion. Spending for hospital care grew 7.3 percent in 1985 and 5.8 percent in 1984, the lowest rates in two decades.

¶The United States spent $371.4 billion last year on personal health care, not counting medical research, construction and administration. Of this amount, consumers directly paid 28.4 percent and private health insurance paid 36.6 percent. Hospital care accounted for 44.9 percent of all spending on personal health care in 19[illegible], down from 47.2 percent in 1982.

¶Medicaid has paid for a steadily declining proportion of nursing home care in the last six years. Medicaid last year paid $14.7 billion, or 41.8 percent of the $35.2 billion spent on nursing home services, down from a high of 48 percent in 1979.

Patients and their families directly paid 31.4 percent of the total spent on nursing homes last year, while private health insurance paid only 1 percent, the report said.

The Cost Of Health Care

National health expenditures in billions of current dollars, not adjusted for inflation, and as a percentage of the gross national product.

		% of G.N.P.
1985	$425.0	10.7%
1984	390.2	10.3
1983	357.2	10.5
1982	323.6	10.2
1981	287.0	9.4
1980	248.1	9.1
1979	214.7	8.9
1978	189.7	8.[illegible]
1977	169.9	8.8
1976	150.8	8.6
1975	132.7	8.3
1974	116.1	7.9
1973	103.4	7.8
1972	94.0	7.7
1971	83.6	7.6
1970	75.0	7.4
1969	66.6	6.8
1968	58.2	6.5
1967	51.5	6.3
1966	46.3	6.0
1965	41.9	5.9

Source: Department of Health and Human Services

Case for New Orbiter Argued

By PHILIP M. BOFFEY
Special to The New York Times

WASHINGTON, July 29 — President Reagan heard final arguments today on whether to build a new space shuttle to replace the lost Challenger and will make a decision on the issue in the next several days, according to Larry Speakes, the White House spokesman.

The chief problem remains how to finance a new shuttle orbiter in a period of tight budgets, Mr. Speakes indicated. These and other space issues were discussed at a wide-ranging meeting between the President and his national security and space aides.

Mr. Speakes said that much of financial discussions so far had focused on cutting other programs in either NASA or the Defense Department to finance a new orbiter but that no agency "wants to give up anything."

He also said that "conflicting views" were expressed at the meeting on how soon it would be before the lack of a fourth shuttle would begin to affect Mr. Reagan's space-oriented plan for a defense against missiles [illegible] to haul cargo aloft, should the nation decide to deploy it.

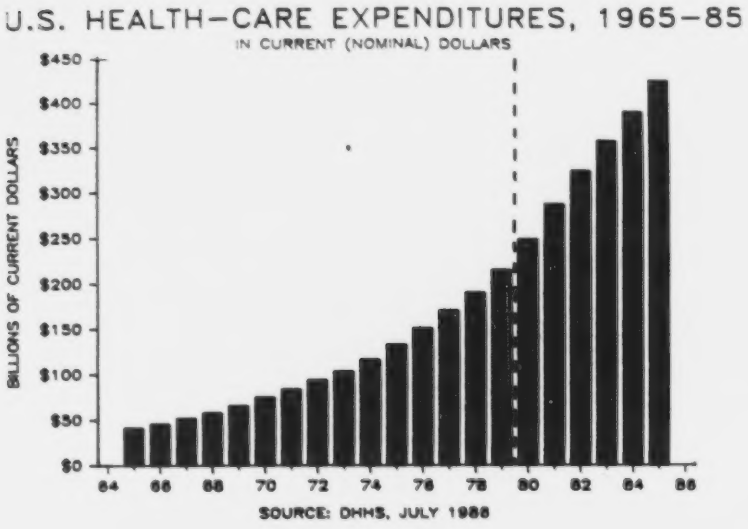
Before the meeting started, Mr. Speakes said he thought the President "basically favors the idea of continuing manned exploration and a fourth orbiter" but added, "There have been a number of questions, particularly centering on funding." Afterward, he said that the President gave no indication as to which way he was leaning.

"The President took the views under advisement and will make a decision in the next several days," he said. If the President decided to build a replacement orbiter, it could be expected to cost $2 billion to $3 billion.

Officials of the space agency were guardedly optimistic after the meeting that they would get the go-ahead to build another orbiter, but they remained concerned about whether they would have to finance much of it from their existing budget.

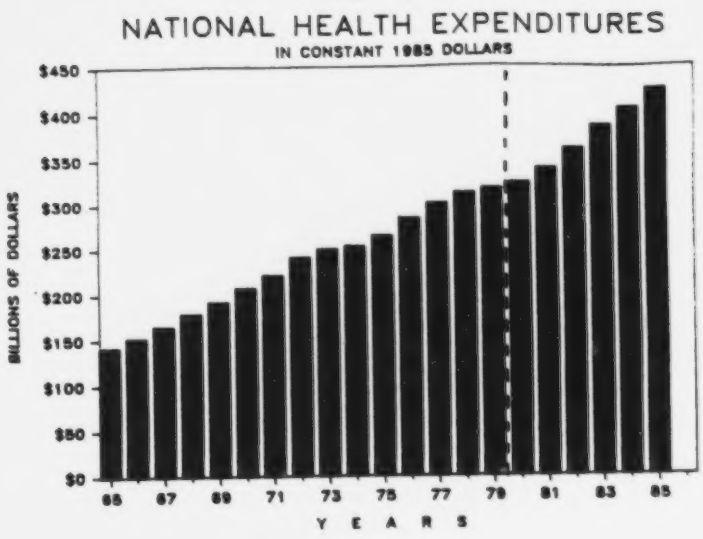
A White House official said he ha[illegible]

FIGURE 1



This diagram depicts the time path of National Health Expenditures in current (nominal) dollars, unadjusted for general price inflation. The curve is smoothly upward sloping and does not show a sharp break with the onset of the "pro-competitive" era or with the DRG era.

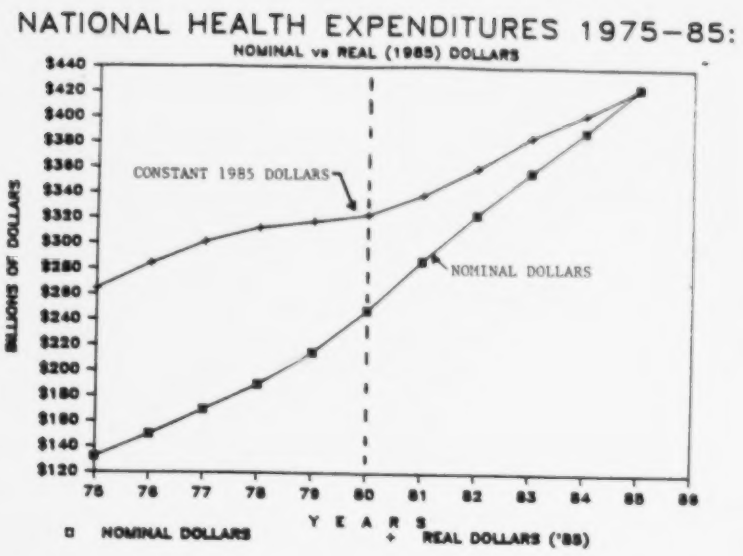
FIGURE 2



This graph shows the trend of National Health Expenditures in constant 1985 dollars. Adjustment for infaltion was made with the Consumer Price Index, All Items.

The diagram shows that, if there is a sharp break at all, it actually occured after 1980, albeit not in the direction one would have predicted for the "pro-competitive" era: outlays actually grew more rapidly after 1980 than before!

FIGURE 3



This diagram compares the time path of nominal National Health Expenditures with that of real (constant-dollar) National Health Expenditures.

Even more revealing is a comparison of annual percentage increases in these two time series, as shown in Figure 4 overleaf.

FIGURE 4

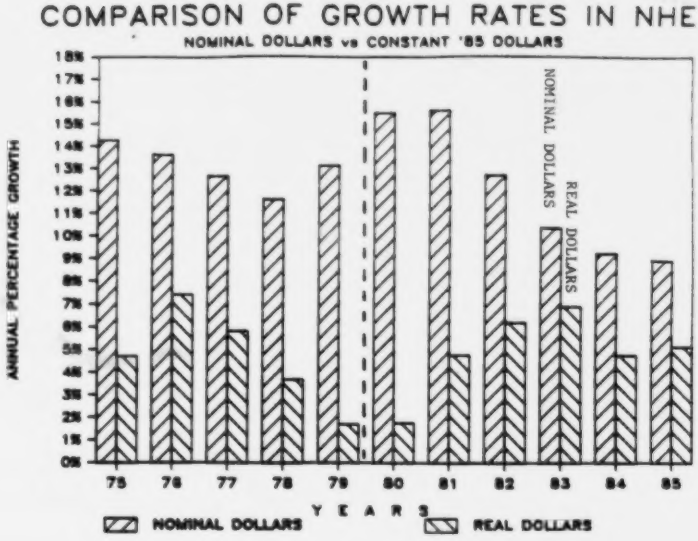


Figure 5 shows annual percentage increases in nominal and real National Health Expenditures for the period 1975-85. The diagram exhibits a remarkable pattern.

During 1977-80, nominal health expenditures grew at ever increasing annual rates. The phenomenon was viewed with great alarm at the time. (See the tall bars in Figure 5).

Actually, the constant-dollar series (smaller bars) shows a declining annual growth rate during that period. We were lamenting general price inflation more than growth in health-care expenditures.

The picture is the obverse since 1980. Since 1980, the annual growth rate in nominal health outlays has fallen, a trend much celebrated by Secretary Heckler and her successor, Secretary Bowen. In fact, however, the annual growth rate in real National Health Expenditures has increased during that period, with the exception of 1984.

It follows that declarations of victory over the growth in National Health Expenditures may be premature.

FIGURE 5

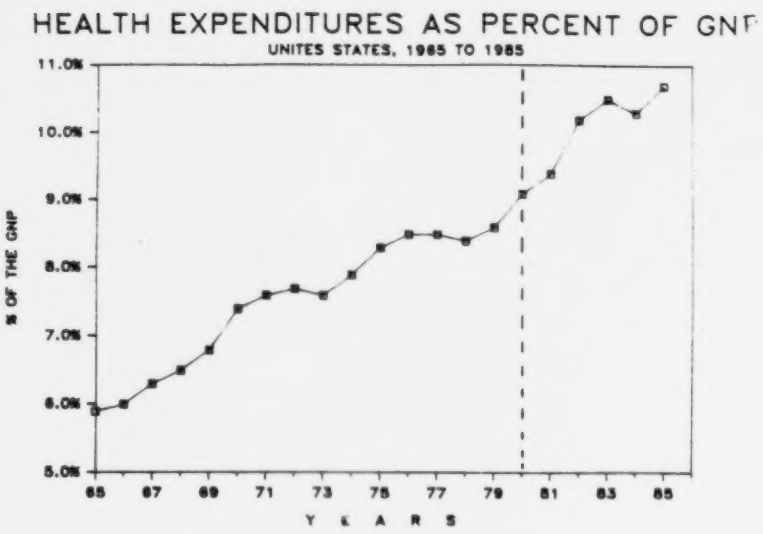


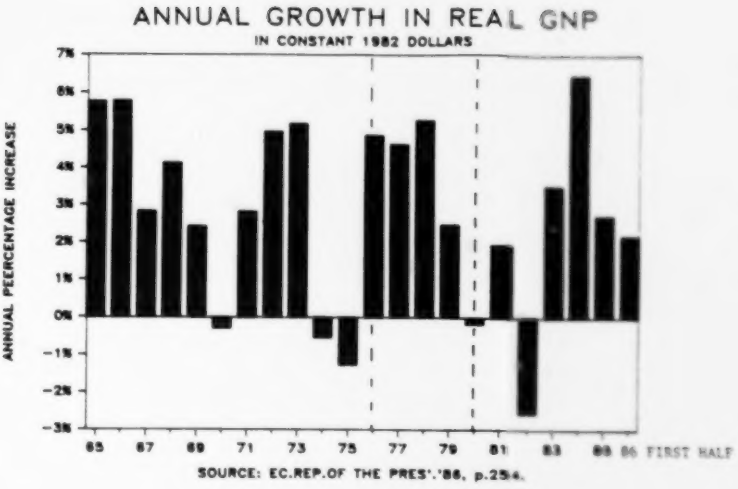
Figure 6 presents the longterm time trend in the percentage of the Gross National Product being devoted to Health Expenditures.

The picture shows wiggles that reflect movements in both the numerator (National Health Expenditures) and the denominator (Gross National Product). For example, the sharp decline in the ration during 1983-84 reflects in good measure the rather sharp increase in the real GNP during that period, as is shown in Figure 7 overleaf.

Figure 6 shows rather clearly that the cost explosion in health care actually began in 1980. During the late 1970s, the ratio actually did not grow very much at all.

Figure 6 also suggests what has been argued earlier: that it may be premature, to say the least, to celebrate a victory over the cost problem in health care.

FIGURE 6



The above graph shows annual growth rates in real Gross National Product, the denominator in the ratio "Percentage of the GNP going to Health Care." The display shows that real GNP grew at an unusually large rate in 1984, which is apt to have contributed to a lowering of the Health Expenditure/GNP ratio during 1983-84. Thus one should not make too much of the downward blip in the ratio during that period. It did not represent the "turning of the health-care supertanker on a dime."

As an aside, it may be noted that the much-maligned period 1976-80 was actually not one of economic stagnation by historical standards, and by the standard of the early 1980s. In fact, during the four-year period 1976-80, real GNP grew at an average annual compound rate of 3.04%. By contrast, during the five-year period 1980-85, real GNP grew at an average annual compound rate of only 2.4%. In retrospect, the period 1980-85 is unlikely to be noted by historians as one of great economic advance. It was a period of boom and bust, with an only moderate average growth performance.

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FIGURE 7

TRENDS IN CONSUMER PRICES 1965–85:

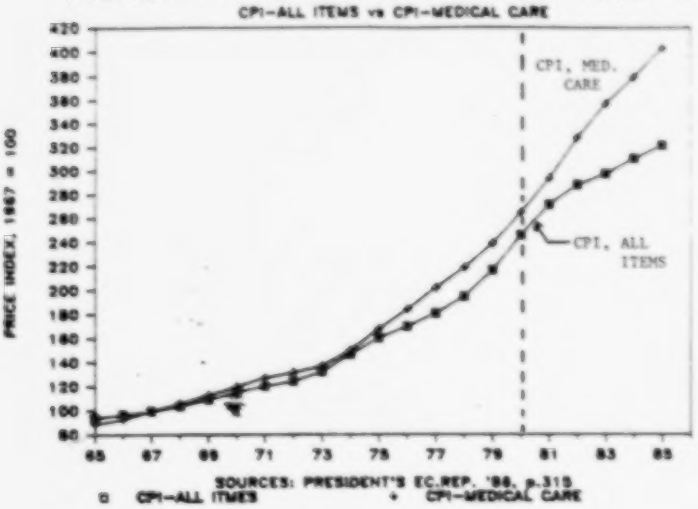
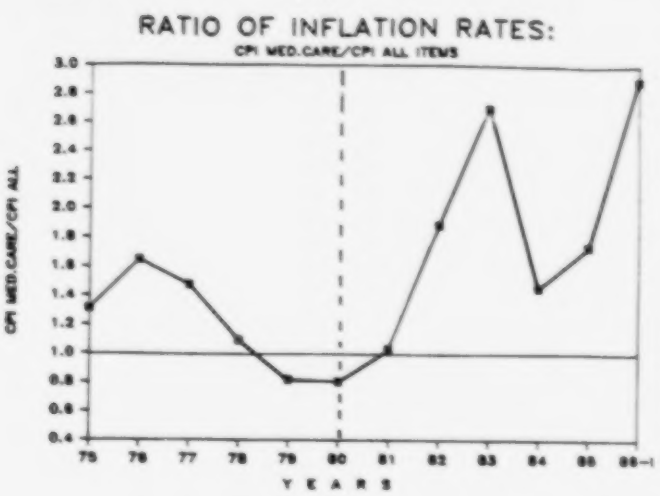


Figure 8 shows movements in two price indeces since 1965:

- o the Consumer Price Index for All Items
- o the Consumer Price Index for Medical Care

The diagram shows how sharply the two indeces diverge after 1980. They began to diverge even before 1980, of course, although there were years in the later 1970s when the Medical-Care price index actually rose less rapidly than the overall Consumer Price Index. The next diagram makes this clear.

FIGURE 8



Inflation is measured by the annual percentage increase in the relevant price index.

If one divides the annual increase in the Medical-Care Price Index by the annual increase in the Consumer Price Index for All Items, then the last ten years trace out the pattern shown in Figure 9.

It is seen that, during 1978-80, the ratio is less than one, which means that Medical-Care prices rose less rapidly than the overall Consumer Price Index.

Since 1980, the ratio has shot up rapidly, rising to almost 3 in 1983 and then, after a decline to 1.6 in 1984, back up to about 3 in the first quarter of 1986.

Actuall, the overall CPI in the first quarter of 1986 fall by 1.9%. That fall was driven by the sharp decline in oil prices since the fall of 1985. If one excludes oil from the CPI, its annualized increase during the first quarter of 1986 was probably between 2% and 3%. In Figure 9, the higher of these figures (3%) was used. During that period the Medical-Care Consumer Price Index rose by an annualized rate of 8.7%.

FIGURE 9

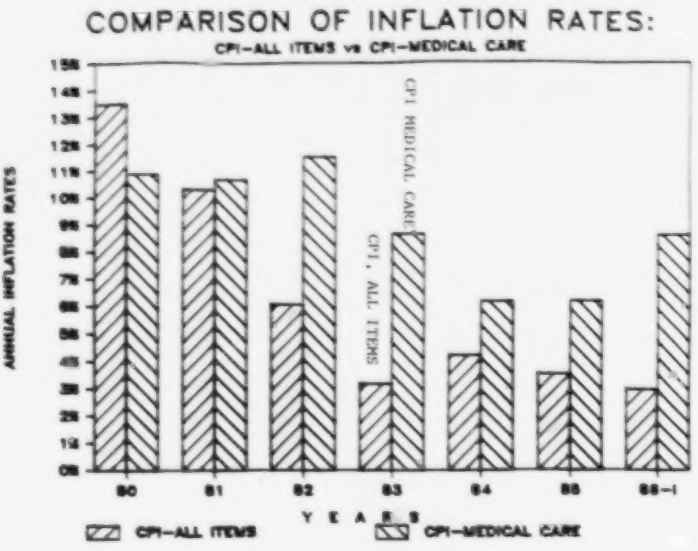


Figure 11 shows the actual inflation rates in the Medical-Care Price Index and the overall Consumer Price Index for the period 1980 to 1985. The ratio plotted in the preceding graph reflects these inflation rates.

FIGURE 10

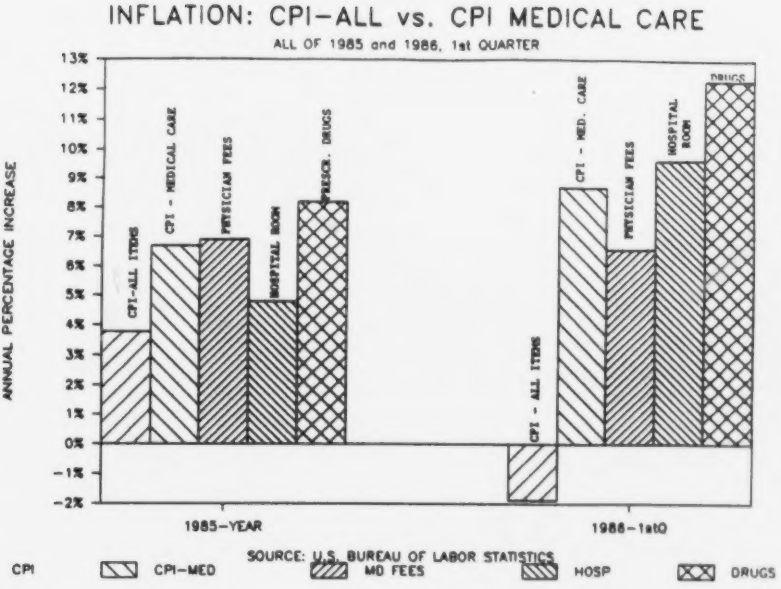


Figure 12 shows annual inflation rates in the overall Consumer Price Index, in the Medical-Care Price Index, and in several of the latter's components, for all of 1985 and for the first quarter of 1986.

It is seen that all components of the Medical-Care Price Index outgrew the overall Consumer Price Index in 1985 and in the first quarter of 1986. With the exception of fees for physician services, the annual inflation rates in the first quarter of 1986 (for Medical Care) were higher than the corresponding rates for 1985. This is brough out more clearly in Figure 12 overleaf.

Note that the overall CPI decreased at an annualized rate of 1.9% during the first quarter of 1986.

FIGURE 11

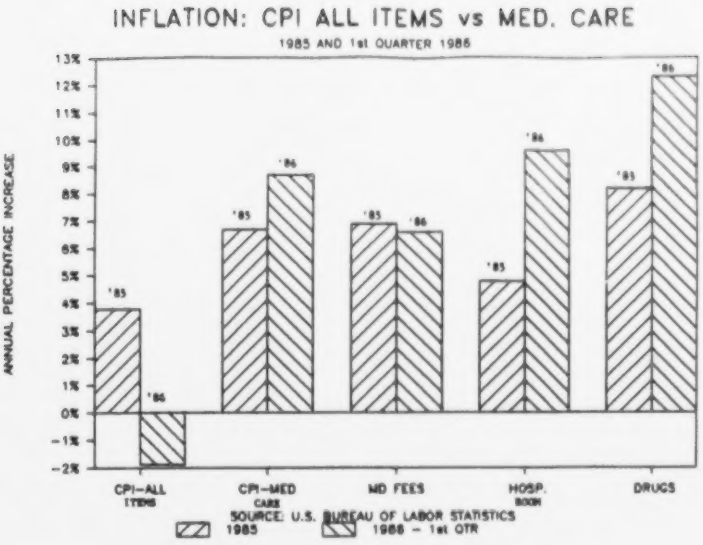


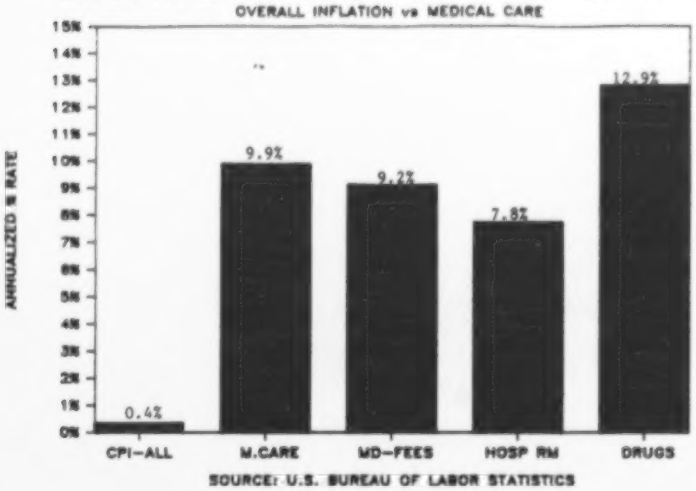
Figure 12 compares the annual inflation rates for 1985 and the first quarter of 1986.

It is seen that the inflation rate for all medical care items other than physician fees rose over the period.

Once again, a victory over price inflation in health care is certainly not evident in these displays.

FIGURE 13

INFLATION RATES , FIRST HALF OF 1986:



Shown in this diagram are the annualized inflation rates that can be calculated from Consumer-Price-Index data published by the U.S. Bureau of Labor Statistics in mid-August, 1986.

These data indicate that the trends manifest during the first quarter of 1986 continue unabated.

The CHAIRMAN. At this particular point, I would like to have your written statement included in the record following your oral remarks and that would include also the recommendation that you made with regard to your two-tier health program, which will, of course, be carefully studied by the committee. We are looking for something that can be done.

The bill that is now under consideration could well not be the answer, but whatever it is, we want answers, and we feel that there is a great need for a national health plan.

However, Dr. Helms, it seems to me that you don't quite agree, that there is a difference of opinion, at least with this panel.

You did state, however, that there are four ways in which medical care is financed at the present time; that one is through commercial insurance, which is two-thirds of all people covered under that. You also have public insurance, which is Medicare and Medicaid. You have State and local governments, which also finance medical care and most of that is for the indigent. Then you have out-of-pocket payments.

But may I ask, if we combine all four plans, can we actually state that all these four plans also include long-term and catastrophic illness?

Dr. HELMS. That is what I was trying to say, that there are real gaps in that system. I think the President's concern and the Secretary's is based on the knowledge that there are real gaps and there are real problems. We have had a whole series of hearings on this study around the country and we have heard numerous stories like the one that Mrs. Gordon told here this morning; they have impressed the people in the Department who have worked on the study and also the committee members listening to the hearings.

If you combine all these things, I think we are saying, yes, there are gaps in the system. But I don't think that calls for, in the old traditional sense, a national health insurance plan.

I know Mr. Flemming disagrees with that. We have tried in this study to analyze all of the options that people have come up with from the academic community, from the Hill here, and others. I think that they are analyzed quite throughly in the report.

We have not gotten to the point where we are making choices about what we are going to recommend. The analysis so far seems to show that we have got specific gaps in the system and we think we ought to use the strengths of the existing system to try to make some changes to address particular gaps, and they are the catastrophic and the long-term care situations.

The CHAIRMAN. But you referred to them as gaps.

Dr. HELMS. Well, traditionally long-term care has not been covered in this country.

The CHAIRMAN. The point is that long-term care has not been covered.

Dr. HELMS. With the exception of medicaid which many people qualify for by spending down. It pays a big part of that total bill although it varies enormously from State to State. Also, we have a very infant industry of long-term care insurance, and some people who are wealthier are buying into continuing care community plans.

But these latter don't cover very many.

The CHAIRMAN. But, Dr. Helms, you know I have a little difficulty with your references to gaps and so forth. I think we must establish the fact that these four plans that you made reference to do not cover long-term care, they do not deal with the problems of catastrophic illness, and therefore, it is more than a gap, it does affect over 31 million people in the United States who are at the present time uninsured.

Would that be a correct statement?

Dr. HELMS. Well, I am not going to get into a discussion of exactly what the numbers are. I think it is a large number.

The CHAIRMAN. What do you think the number is that are uninsured? Our numbers are 31 million uninsured. Reference has been made that there may be as many as 40 million.

What is your figure?

Dr. HELMS. There is no single aggregate number that I consider satisfactory.

The CHAIRMAN. But we do know that there are millions that are uninsured.

Dr. HELMS. Agreed.

The CHAIRMAN. But we don't know whether there is 20, 31, or 40 million?

Dr. HELMS. But I will say traditional insurance provided through employers has changed a lot over the last few years in the sense that there is much more catastrophic coverage. I think that Dr. Reinhardt will probably agree that among economists we think there is enormous promise for the concept of catastrophic insurance. Certainly for acute care because it is such a rare event.

And even if you look at the statistics on catastrophic long-term care—depending on your definition—it seems that it should be insurable.

What we are looking at are the things the Federal Government can do to try to take away the barriers and the disincentives that the commercial insurers have had for providing these kinds of insurance. We think there is great promise for that.

The CHAIRMAN. You spoke on ways to reduce or redefine the un- or under- insured, but you barely mention what the administration is doing to protect these Americans. Can you tell us what these specific plans are for insuring coverage and access to acute and long-term care for Americans of all ages?

I think we have established the fact that we do agree there are millions and while we disagree on the number, I say 31 million, you may say less, but there is a need for millions of people—a need for long-term care assistance.

Does the administration or your Department have a specific plan to address itself to these problems whether it be 31 million, 10 million or whatever it is, whatever number you have. Do you have a plan?

Dr. HELMS. Not at this point. What I have tried to say several times is that no decisions have been made. But there is a desire to see what we can do with this. We are looking at several options, different kinds of plans, that have been put forward for increased long-term care insurance, for different spend-down provisions, for reform of Medicaid, for things like home equity conversions.

We have gone through a number of these different options. I think most are in the literature. We have tried to do an analysis on all these.

Which ones we might propose has not yet been decided.

The CHAIRMAN. Has your Department established who has the responsibility for caring for the poor? Is it just Medicaid? Do we have any other plan?

Dr. HELMS. Well, again, the low income and the indigent are a substantial part of the study. We are even trying to analyze the effects of the tax reform legislation on this. The Federal Government has a certain responsibility but I don't think in any sense are we going to say that the Federal Government should take all that responsibility.

The CHAIRMAN. Dr. Helms, I was in social work many, many years ago and I remember coming to a conference in Washington, DC, on health care and remember recommendations—resolutions and recommendations that were passed. At that particular time—this was before medicare, of course—recommendations were being made to establish a system where the Government could do certain things. Since then health educators and people in the health field have studied it. We continue to study the problem. We know there is a need.

Why haven't we done something about it up to this time?

Dr. HELMS. Well, because I think that is what Professor Reinhardt was getting at. Proposals that would wipe out a major part of this insurance industry are just not politically realistic.

The CHAIRMAN. Do you think that the proposed plan, the US Health plan, if you have read it, do you think that it is designed to wipe out anything?

Dr. HELMS. I have not had the chance to study it in detail. I think the financing part of it is probably not realistic, but I do like certain features having to do with prepaid plans.

The CHAIRMAN. Since you brought up the financing end of it, I have a chart here that shows that back in 1967, U.S. health care expenditures were in the neighborhood of $50 billion. In 1980, it increased to $250 billion. Today, in 1986, it is in excess of $400 billion.

If it continues to go at this particular rate, it will definitely exceed 12 percent of the gross national product. Now, the question that comes to mind, can we afford to exceed that or can we better afford to set up a system that has cost containment and, at the same time, provide care at either 12 percent of gross national product or less? What choice do we have?

Which would be better? To continue what we are doing or to come up with a plan that can modify the situation to the point where the delivery system can be made available to all regardless of income?

Dr. HELMS. Mr. Chairman, let me say that it is very difficult for any economist to say what appropriate percent of the gross national product should go for health care.

I think that the health insurance industry is going through a change, and I think it needs to be speeded up. But one of the biggest difficulties that all economists get into is trying to predict the future. I read somewhere recently that Mr. Penner, of the Congres-

sional Budget Office, said we economists can't even predict the past. I would like to see a system that gives a lot more incentives for everybody to be efficient. In that sense, I think that what percent of the GNP ends up going for health care would be a matter of consumer choice as opposed to Government mandate.

I do not think governments can really regulate this in any very efficient way.

The CHAIRMAN. Has your Department designed such a system?

Dr. HELMS. We have taken several stabs at it. The Congress hasn't paid much attention to our previous attempts. We hope when we come out with a catastrophic plan that we will have some reform features that the Congress will be interested in.

The CHAIRMAN. I don't know of any plan that has been submitted that deals directly with the problem that we have been discussing or that in any way would resemble putting in place a national health system, at least not one that has come from your Department or any other department of the Federal Government.

Dr. HELMS. Well, the Department of Health and Human Services did put forward, in about 1983, several plans, one to change the tax treatment of health insurance to get at the problem I think Professor Reinhardt was talking about.

The CHAIRMAN. But that was not a catastrophic health plan, was it?

Dr. HELMS. Not in that sense, but it had several features that we felt got at the main problems. We also proposed a plan to restructure Medicare to improve catastrophic coverage for Medicare recipients.

The CHAIRMAN. I remember those particular struggles and remember what took place at that particular time. However, the constant reminder to the Congress was that things were costing too much, that we couldn't afford more than what was being recommended.

Dr. Reinhardt, as an economist, can we afford a national health plan?

Mr. REINHARDT. There is no question we could afford it. There is no question we could spend 12 percent of the GNP on health care without harming the economy. Whether you may want to do that is, of course, another question. Perhaps with some impudence, but to make a point, I attached to my formal statement a picture of our allegedly budget-conscious President in which he boldly takes credit for spending this fiscal year, $26 billion on agricultural support programs. I read that that program's cost is expected to go to $30 to $35 billion in the next fiscal year. This is money that goes primarily to induce farmers not to grow food, and much of it winds up in the pockets of well-to-do farmers or agribusiness.

It is my view that a Nation that can afford to pay that much money to prevent the growing of food, and that spends so many billions on weapons of dubious quality could easily afford to spend 12 percent on health care if that is what it takes to keep our system both humane and the best in the world.

The other thing that is often overlooked which I point out is that it is a little odd that we salute as a sign of national health when expenditures on automobiles go up but somehow as a sign of major calamity when health care expenditures go up.

One really has to ask ultimately in either case, are the expenditures we make worth the benefits we buy with it?

I think we want our physicians to live well. I don't think there is a national mood to underpay physicians.

I think we want our hospitals to have balanced budgets and our nurses to be well paid for the work that they do.

The product delivered by the health system is much appreciated by the American people, and thus I think this Nation will have no trouble spending 12 percent or so of the GNP on health care if that burden is fairly shared by the people.

In fact we could afford an even looser and more expensive system and not mortgage this country anymore than it is, in fact, being mortgaged in many other more dubious ways under current Federal policy.

The CHAIRMAN. Dr. Flemming, what is your opinion with respect to, No. 1, the need which you have emphasized, and second, can we afford it. Do you agree with Dr. Reinhardt?

Mr. FLEMMING. Mr. Chairman, in my opening statement, I think I did point up my own convictions relative to the need. I just think we face a desperate situation in this country in this area at the present time and it is growing. You have talked about the number of people who are uninsured. Back in the latter part of the 1970's that number—as I recall, it was around 27 million; it is now, on the basis of the figures that I have looked at from the Census Bureau and so on, moved up to approximately 40 million and it keeps growing.

We are not solving it in any sense of the word at all. Our system is a patchwork system. There isn't any question about that at all.

I find myself following Dr. Reinhardt without any difficulty at all in terms of his comments on our system and in terms of his comparison of what we confront in this country with what people confront in other countries where there is a national health plan in effect.

Research of the other countries he mentioned, of course, has a national health plan. As he said, the kind of situation that we confront you can't imagine existing in those countries.

In terms of—let me say this. I followed Dr. Reinhardt all the way through to his specific proposal. I recognize that if we have a national health plan that there will be two tiers, but I see no reason at all why we should settle for anything less than exists in the other countries. In other words, that 90 percent of our people would be under the universal health plan and maybe 5 to 7 or 8 percent of them would opt to be on the outside.

I do not see any reason at all why we have got to settle for 20 and 80 percent. Of course, I recognize that the poor are really up against it, but the thing that I am struck with is that under our health care system we tell people that you can't be helped or assisted in any satisfactory way as far as long-term care is concerned unless you spend down your resources until you become one of the poor.

In other words, that situation to me is intolerable and so that I feel that we must move for the kind of a plan that is reflected in your bill.

On the cost side of it, as I indicated in my testimony, as I travel the country, as I talk to audiences oftentimes of older persons, but other times made up of other age groups, I am frankly an advocate for a national health plan and I tell them that I feel that you are providing the Nation with the kind of leadership that we need in this area in introduction of this bill and the content of this bill.

I have questions and answers always afterward, and the first question I will get is, well, aren't you dreaming when you are out here advocating something like this when we got $200 billion deficits and we have a national debt over $2 trillion and so on, and I know that that is an issue, and I know it is an issue that we have to confront.

But I try to then talk with them about Canada and the United States and the fact that 20 years ago we were both in the same boat as far as our expenditures for health care, about 6.5 percent gross national product.

Canada in the early 1970's put a national health plan into effect including cost-containment features just as your bill contains cost containment features. Where are they today?

They are at 8.4 percent. I suspect—I know you can go up there and some people will feel there are some things that are not in that package that ought to be in it and so on, but the point is that research has access to adequate health care up there.

They got over that particular hurdle. But here we are at 10.7. We have jumped from the 6.5 of 20 years ago and we are up to 10.7. We have still got roughly 40 million people on the outside looking in.

Well, there is something wrong with that. We are spending money that falls under the label of health care which really isn't health care. The best example of that that I can think of is the millions we spend on determining whether people are eligible for Medicaid and that gets more complicated all the time.

We keep spending more money on it, not less money on it. What good does that do anybody as far as health care is concerned? That is money down the drain.

We make it available to research, and that opens it up. For research you don't have to spend money for that particular purpose.

As I indicated to you, former Secretary Phil Lee, former Assistant Secretary for Health, really believes that the savings that are built into a national health plan plus the kind of cost containment that is included in your bill could add up to the fact that we could have a national health plan without an increase in our present GNP.

Now, he may be a little overly optimistic in that, but he is an expert and he follows this constantly day in and day out. But assuming he is, if we have to go up to 12 percent, are you telling me that we can't afford 12 percent of GNP in order to at long last implement the right of access to adequate health care—that doesn't make sense.

We do have it. We do have the physical capacity to do that. I can talk about things that we are spending money on that we don't need. I am encouraged over the fact that the Congress at long last is beginning to bring defense expenditures under control.

Of course, I agree with Dr. Reinhardt and I agree with George Will, we are the most undertaxed democratic democracy in the world and we can get additional revenue in that particular way.

I like your package. I might like something else. I think Dr. Reinhardt has made a couple suggestions here on getting revenues that are important and I might like to drop out some things and put in some things.

But the point is we can put together a package that would establish the trust fund on which people could count and that package can be put together in such a way that it will not undermine in any way the fiscal integrity of our Nation.

The CHAIRMAN. Thank you, Dr. Flemming.

I agree with you. I think we can put together a package. I think Dr. Helms has stated that the administration shares the concern of this committee and the advocates of a national health plan.

There is a difference of opinion as to what can be done. There seems to be also a difference of opinion as to the number of people that are underinsured or uninsured.

I don't see how that difference can come about because that comes from the most reliable source—the Federal Government. However, there is difference at least at this meeting. Dr. Flemming, you raised your hand?

Mr. FLEMMING. Just one additional point I would like to make based a little bit on Dr. Reinhardt's point. He said he likes, obviously, the thrust of your bill.

But he says he wonders whether we can really move forward with this kind of an approach in our present political and moral climate.

I am a little more optimistic on that. I feel that out of the grassroots there is a political and moral climate that will respond to leadership on this.

The people out there are very, very unhappy over this situation. Well, a lot of them are suffering.

A lot of them are scared to death that their families will be put in that particular position and so on.

But they have not had a handle to take ahold of. The introduction of your bill, holding of these hearings, and the other hearings that you will hold and then if the other committees pick this up and begin holding hearings, will give them a handle to take ahold of and I can guarantee you that the Members of the House of Representatives and the Senate are going to hear from the grassroots on this. You asked another witness a little earlier whether there would be a coalition on this.

There will be a coalition—there is a coalition on this in the process of forming, and it is going to be one of the most broadly based coalitions that we have seen on any issue over the period of the last 20 or 25 years.

It cuts across political lines. It cuts across ideological lines. It cuts across economic lines and I think that there is a political and moral climate out there which if we give them a handle, give them something very, very specific to react to, is going to respond in a way that will surprise the Nation.

The CHAIRMAN. Dr. Flemming, I think you read my mind because I was going to bring up this matter of the coalition and include Dr. Helms in this particular discussion.

The truth of the matter is that we have a situation where Dr. Helms and his Department do not agree completely. He does agree that there is a need to do something.

But he doesn't agree with the recommendations that we are making. On the other hand, Dr. Helms, I find that there are no recommendations forthcoming from your Department with respect to this matter; is that correct?

Dr. HELMS. Absolutely not. The President has asked for a report by the end of this year. That report is being prepared. The Secretary has not seen the analysis yet. We are discussing this within the Department, going over the analysis, identifying a good set of options from which he and the President will decide what they will propose.

But there will be a definite plan as I have said, and I think it is going to be concentrated on the problems of catastrophic care.

The CHAIRMAN. The President made such a statement, and there was great response throughout the Nation. That, I think, is what Dr. Flemming makes reference to. The people of the United States are ready for something.

My reference to the fact that nothing has been forthcoming from your Department or the administration is based on what I know to be a fact as of today. The fact that you will in the future bring something to the Congress is something that we will await with great anticipation. If it is going to address itself to the problems of long-term care, catastrophic care, and those things we have been discussing, we can assure you that the Congress will take a look at it with great interest and use it to great advantage.

You stated that you had not read the piece of legislation that this committee has presented. May I recommend that you do?

It is not perfect and if you can improve it and send a recommendation to this committee with the support of your Department and the administration and call it by some other name, it is perfectly all right with us.

What we want is to do something. The need is great and while you have acknowledged this great need, you have not quite agreed with the urgency of the situation.

Do you think there is a possibility that the coalition we talked about, and you heard about in our discussion with respect to coalition, could include your Department?

Dr. HELMS. I have no way of knowing. At this point, we must first decide what we are going to do. To the extent that our proposals are consistent or inconsistent with your bill, a coalition would be something I think we might consider.

The CHAIRMAN. At least we have an assurance then that something will be forthcoming soon with regard to this subject matter and that we will address our attention to it. At that particular time, we may be able to sit down and talk about means and ways of coordinating our activities and coming up with a plan that could make some sense.

Dr. HELMS. Mr. Chairman, we certainly can't object to that.

The CHAIRMAN. Right.

Since we seem to have reached at least one item that is in agreement, I wish to thank the witnesses for your testimony. It has been most interesting and most informative. I like the fact that experts disagree on the method. You don't disagree, I don't think, that there is a problem. It is that problem we want to attack. If we can do it in a bipartisan way, I think that may be the way to go. We have to do something, Dr. Helms, Dr. Flemming, and Dr. Reinhardt, and we take your recommendations seriously and we thank you for your appearance this afternoon.

The hearing is adjourned.

[Whereupon, at 1:34 p.m., the hearing was adjourned.]

APPENDIX

PREPARED STATEMENT OF DOUGLAS A. FRASER, CHAIRMAN, HEALTH SECURITY ACTION COUNCIL, WASHINGTON, DC

Mr. Chairman, Members of the Committee: I am sorry I am unable to appear in person at the September 12, 1986 hearing on H.R. 5070, the USHealth Act of 1986. The dates earlier selected for this initial hearing were compatible with my schedule. Regrettably the current hearing date conflicts with a long-standing earlier commitment I have outside of Washington.

I have been particularly eager to appear before this committee because our Health Security Action Council and its companion organization, the Committee for National Health Insurance, have had a deep and continuing interest over the last 17 years in seeing that a comprehensive solution is achieved to this nation's worsening problems. We need to make available to the American people a decent level of affordable health services.

We are dismayed by the continuing erosion of protection and the series of proposals by health policy makers which offer partial, inadequate solutions to major problems which require comprehensive, universal approaches.

We therefore applaud Congressman Edward R. Roybal and his colleagues for introducing a new effort to provide an essential program. We hope and expect this will re-stimulate the debate, bring about renewed examination of the issues and proposed solutions, and eventually offer the American people needed federal, state and local leadership in providing priority health services not now available to too many Americans.

A Massive Problem

The most important single fact the American people need to know and understand is that the number of Americans without any public or private health insurance or with inadequate protection has been increasing year by year. According to the federal government's National Center for Health Services Research (Department of Health and Human Services), 30.7 million Americans under age 65 have no private health insurance, inadequate protection, and no coverage from public programs. The persistence and increase in this large population impose major costs on all of our society.

Having a job doesn't necessarily provide protection. Almost 65 percent of the uninsured are working adults and their dependents (1983). One-third of the unprotected are children.

Medicaid has proved not to be a major source of financing of medical care needed by the poor. In 1984, it covered less than 40% of the poverty population and had become primarily a supplemental insurance plan for those receiving medical services under Medicare. Only one quarter of its expenditures went to pay for actual medical care for the poor under 65.

The problem of inadequate health care protection is pervasive, nationwide, and a present danger to the well-being of our country.

New Threats

The American health care system is in chaos, as business and labor, providers and consumers seek to find effective means of controlling escalating prices and costs. Many economists are congratulating Americans on how well inflation has been contained. But health services prices continue their excessive rise. In July, 1988, compared with a year earlier, there was only a 1.6 percent increase in all prices. In the same period, medical care prices increased four and a half times more rapidly (7.8 percent). And national per capita expenditures on health services have reached an all time high.

Workers wages and the incomes of those on fixed pensions and Social Security have not increased at nearly a commensurate rate. Employers, pressured to contain runaway health costs, have sharply escalated insurance deductibles, co-insurance, and employee premium-sharing. The Congress and the federal government, faced with monumental annual deficits, seek in part to reduce them by gradually shifting the responsibility for the payment for health services for the elderly and disabled to private employers and the states.

One of the newest crises has arisen as American corporations, led by the LTV Corporation, the giant steelmaker, began to terminate retiree health benefits for which they have been committed for years. It is troubling to hear business spokesmen now refer to retiree health insurance, not as deferred compensation, as the U.S. Department of Labor and others have always characterized it, but as an unfunded liability for which the corporate employer does not necessarily have a continuing obligation. Some 7 million retirees now protected by employer health plans, particularly those not yet aged 65, are both astonished and threatened by the possibility that they may lose long-expected health services protection at a time when the workers are no longer a part of the work force.

Fragmented Approaches

The experience of the last several decades has taught us that, in the absence of a comprehensive universal national health program, serious inequities and runaway costs are inevitable. We have further seen demonstrated that fragmented approaches to solving problems of health services are usually futile, expensive and frustrating. Special projects for some of the poor, proposals to compensate hospitals for portions of services for which they don't get paid, plans to require employers or their laid-off workers to maintain insurance protection for several months after lay-off, the establishment of state risk pools to provide insurance coverage for "uninsurable", usually handicapped, persons are well meaning steps in the right direction. But over forty years of experience with these kinds of limited proposals have shown they don't go far enough to provide meaningful protection to the increasing tens of millions of Americans without public or private insurance.

And it is contrary to good public health policy to revive proposals for types of so-called catastrophic health insurance which do not pay for real health catastrophies. It is counter-productive to suggest that the health of the elderly and severely disabled would be improved if the social insurance basis of Medicare were destroyed by requiring actual or disguised welfare-oriented means testing for Medicare beneficiaries.

We are, therefore, pleased to see that H.R 5070 takes a comprehensive approach to American health care. It offers protection for everyone. It establishes a full range of needed benefits and provides for safeguarding the quality of care for which the plan will be paying. It focuses appropriately on the priority health needs of the nation, including an effective long term care program. It recognizes the importance of consumer participation in policy development.

We believe the plan, as structured, can be cost-effective and, at the same time, provide needed consumer and patient protection. As you well know, the approach in this bill, in one form or another, has been adopted by almost every industrialized or semi-industrialized nation, except South Africa.

There are aspects of the legislation which we believe could be strengthened or modified. Our own Council has been at work developing a new national health proposal which we hope, before long, to announce and which we believe will provide an approach to a national health program which will be aimed at the same objectives as H.R. 5070. However, H.R. 5070, and you, Mr. Chairman, who has introduced it, do a real service to the American people and to the Congress in reopening the debate on the need for comprehensive change and on proposals to bring about essential alternatives to the current methods of financing and delivering needed health care services.

We look forward to cooperating with this Committee in a serious new examination of the issues and proposed solutions. Above all, we are pleased that it is your intention, Mr. Chairman, that they are to be discussed in the context of universal citizen participation, a comprehensive benefits plan, and health system reorganization.

The Health Security Action Council is a national consumer-oriented health policy and action organization of national leaders and a network of labor, business, women's, youth, senior citizen, education, religious and farm organizations. Its aim is to develop, promote and secure the adoption of measures to improve the nation's health.

PREPARED STATEMENT OF BARBARA A. ROHAN, R.N., M. ED., PRESIDENT,
RE-HAB ASSOCIATES, INC. & SPORTS MEDICINE CENTER, WEST SPRINGFIELD, MA

Mr. Chairman and Members of the Committee:

I am Barbara Rohan, President of Re-Hab Associates, Inc. and the Sports Medicine Center in West Springfield, Massachusetts. I am appearing before the committee today on behalf of the National Association of Rehabilitation Facilities (NARF) of which I am a member. We are very pleased the committee and its chair are taking such an aggressive role in addressing the health needs of all Americans and particularly the need to address catastrophic injuries, and the concomitant catastrophic expenses including long term care.

NARF is the national voluntary organization of community based rehabilitation facilities. Its membership includes over 600 facilities including freestanding rehabilitation hospitals, rehabilitation units in general hospitals, outpatient rehabilitation facilities and vocational developmental centers. They serve over 700,0000 persons with disabilities annually.

The objective of medical rehabilitation is to restore people who suffer from illnesses, injuries or congenital deformities to their maximum functional level. A recent study by NARF revealed that the average length of stay in these facilities is 34.1 days and the average charge per case exceeds $15,000 with charges ranging considerably higher for certain injuries. These figures reflect only <u>inpatient</u> medical rehabilitation costs. These costs are catastrophic for any individual or any family with a member who suffers from a stroke, brain injury, spinal cord injury, various forms of arthritis, congenital deformities and other major traumas. Over 80 percent of the people sent to rehabilitation hospitals and units return home. Only 17 percent are referred to skilled nursing facilities. Rehabilitation services include physician services, rehabilitation nursing services, physical, occupational, speech language pathology and audiology services, psychological and social services, recreation therapy services as well as equipment and supplies.

Many rehabilitation patients require extensive outpatient rehabilitation services delivered by either freestanding

outpatient facilities, home health agencies, hospital outpatient departments and rehabilitation agencies.

We commend this committee for addressing the tremendous costs associated with a serious illness or injury and for proposing a mechanism to meet these expenses. We urge the committee, in its consideration of any final proposals to the Secretary, to look at the need for catastrophic health insurance which addresses both inpatient and outpatient medical rehabilitation needs for the total population - the employed, unemployed, underemployed, the poor and the Medicare population. We also recommend that you include long term care insurance in any final recommendation. We make this statement in view of all our facilities' professional experience with the catastrophic and long term care needs of rehabilitation patients whether the services are delivered at home or in an institution.

Catastrophic insurance is generally defined as coverage for large health care expenses, usually measured annually and caused by the onset of a serious chronic illness or an accident resulting in recurring, costly treatment and, frequently, repeated hospital admissions.

The committee has, I believe, already heard extensive testimony about why existing health coverage does not adequately address the needs of many patients. The problems in Medicare, Medicaid and commercial health insurance are magnified 100 fold when focused on a patient needing rehabilitation services. There are glaring gaps in coverage and payment for patients needing rehabilitation services and disabled individuals with residual impairments who incur continuing costs for medical, health and personal care needs.

Most Americans have some form of health insurance. However, it may be limited by maximum dollar expenditures and/or the scope of covered services. Medicare and Internal Revenue tax subsidies help pay for these extraordinary expenses, however, there are over thirty-five (35) million Americans who have no or limited health care insurance. There are also thirty-six (36) million Americans with disabilities. Of this group approximately one third do work and receive no public assistance. One quarter are receiving public assistance but are not working. The balance receive public assistance and 9 percent of them work. However,

the nature and extent of their health care coverage is not well known.

Studies show that half of those who spend more than $5,000 per year for medical expenses are in institutions. 1.3 percent of the population accounts for more than 50 percent of all charges in short stay hospitals, and this pattern holds across all age groups. If data on long stay institutions is added, approximately 3 percent of the population accounts for over 60 percent of hospital and institutional care expenses each year. High family costs tend to be concentrated on one family member. Also, high cost illnesses are repetitive and result in repeated hospitalizations, and, these costs began before and continue after the year measured in the studies. Disabled Medicare beneficiaries use nearly twice as many Medicare services as the elderly and use them more at every expenditure threshold.

The most recent study from the National Center for Health Care Statistics show that

> a fifth of the nation's 88 million families incur "catastrophic" out-of-pocket medical expenses--costs that absorb an abnormally high percentage of their total income. Nearly 16 million families spend 5 percent or more of their annual incomes on out-of-pocket medical costs, even though these expenses average under $100 a year in nearly a third of the cases... Half spend 10 percent of their earnings on medical care, and over 3 million families use at least 20 percent for the same purpose. Hospital care is the biggest expense for the 16 million families with large medical bills. Nearly half of the money by families in the 10 percent bracket, for example, goes toward hospital inpatient services--nearly twice as much as for families as a whole.
>
> While some of the 16 million families incur catastrophically high expenses in spite of fairly comprehensive insurance coverage, most face a combination of little or no insurance coverage and low income. In fact, two-thirds of families with high out-of-pocket medical expenses have incomes below the federally set poverty line. Many of these families are headed by an unemployed person under 18 or over 65 years of age. Among those with some public or private insurance, coverage varies according to the ratio of direct expenses to costs of families in the 5 percent expenditure bracket, but covers 28 percent of the total costs for those in the 20 percent category. Conversely, the share paid by Medicaid and private insurance declines as out-of-pocket expenditures rise in relation to income.
>
> Besides spending a large portion of their income on medical care, families with high out-of-pocket costs account for a disproportionate share of the health care expenditures of U.S. families as a whole. For example, families in the 5 percent expenditure bracket account for more than 40 percent of all health care expenditures; those in the 10 percent group are responsible for a quarter; and families in the 20 percent expenditure group account for 13 percent.

Our members have found that rehabilitation patients easily exhaust their health care coverage or require extensive services which are not covered. In either event the patient and the

family, if a family support system exists, are confronted with excessive financial burdens for the services. If the patient is unable to pay, our facilities must decide under what conditions to provide the services. Many non-profit facilities are required by their charters to serve patients without regard to their ability to pay which may cause excessive financial burdens for a facility.

A brief study of insurance coverage by NARF has revealed that rehabilitation services needed by patients depends upon whether a patient is hospitalized, since nonhospital custodial or skilled nursing home care or extensive home health care is frequently not covered except under Medicaid and partially covered under Medicare. This limited coverage, which is dependent upon hospital stays, does not address chronic illnesses or disabilities which require intermittent hospitalization and home health or nursing care.

Additionally this study highlighted the problems that exist under commercial health insurance with coverage for rehabilitation services. Recently the Washington Post carried a four part series on the experience of a Virginia family when their 20 year old son was in an automobile accident and suffered severe head injuries. This article traced his care from the shock/trauma center through his rehabilitation. The excellent series highlighted all the emotion, time and money which a family experiences when a member suffers a catastrophic illness.

The second article in the series highlighted the problems the family faced when he was ready for rehabilitation. When the family sought to have him moved to a rehabilitation unit in a local hospital, (which is a NARF member) they discovered that their health care coverage through the federal government, a health maintenance organization (HMO), Kaiser Permanente did not cover rehabilitation services. The article notes that the son had been in a trauma center hospital for 78 days before being transferred. According to NARF's recent study the range and length of stay once a patient is referred for rehabilitation services for a head injury is from 12 to 88 or more days. Again, this is only for the inpatient hospital rehabilitation stay and does not account for the services needed after discharge from the hospital.

With respect to this particular case the bills were sky high.

The shock/trauma charges alone were over $100,000. The family had never worried about bills before, assuming that the medical insurance through the father's employment covered all possibilities. The family, like many families, had no reason to believe that they would find themselves without coverage. Once the son began to emerge from a coma and qualified for a rehabilitation center, Kaiser Permanente first stated it would pay none of the cost, estimated at $10,000 per month, for rehabilitation at a rehabilitation center near their home. The family, upon reviewing the benefit booklet which had been supplied, found at the very end of the list of exclusions under "What Is Not Covered" an exclusion for "the services of a rehabilitation center." These types of exclusions are not uncommon in commercial insurance coverage and are particularly common with HMOs. Frequently, a company will say that the services of a rehabilitation hospital are not covered because the hospital does not meet the plan's definition of a hospital, usually because it requires surgical facilities on the premises and does not recognize a contractual arrangement with another local facility. A second frequent type of exclusion, cited in the article is that the insurance does not cover care which is primarily for rehabilitation, convalescence or custodial care. However, this particular health plan would cover 100 days a year if the son were in a nursing home as opposed to a rehabilitation center. The family's only other option was to qualify for Medicaid but the only state approved Medicaid facilities were 100 miles away.

After a second opinion and repeated interviews the HMO agreed to pay for four more weeks of care in a general hospital while the son received speech and physical therapy. It still would not promise to pay for long term rehabilitation once the son left the hospital. Eventually it agreed to pay for only 60 days of rehabilitation care in the rehabilitation unit of the local hospital.

When interviewed, the company stated that it tries to predict how many catastrophic bills it may incur and, while it may be willing to absorb "our fair share of cases like this," it did not want to price its product out of the market and suggested that families obtain major medical policies for an additional monthly premium. The Post noted that major medical policies can be difficult to obtain and that Kaiser and most HMOs simply do not offer them.

Almost a year after the injury, the son continues to make progress in the rehabilitation unit. After intervention by the governor, the hospital was qualified by the state to treat Medicaid recipients. One wonders why obtaining coverage had to be so difficult!

Existing coverage has a high institutional bias. If services are to be received, they are generally available only when a patient remains in a hospital setting. Hence, there is often inappropriate institutionalization and unnecessary care for some patients, and inadequate or unavailable services for others. After hospitalization, a patient is frequently referred for outpatient services, home health care or skilled nursing care. When a patient's coverage is exhausted or the needs less intense services which are not covered such as nonskilled services, simple custodial care, respite care or home health aid care, these services are withheld. The patient's health may decline demanding readmission to a hospital and the cycle begins anew. So do the costs. These problems are becoming increasingly acute as our nation ages and as medical technology saves more people, but leaves impairments requiring extensive rehabilitation services. Those over age 65 will comprise 17.3 percent of the population by 2020; those over 65, 2.4 percent.

The objective of medical rehabilitation is achieved through integration of medical and social services. As noted, the types of injuries and illnesses which are treated by rehabilitation medicine include spinal cord injuries, stroke, head injuries, amputations, soft tissue injuries, arthritis, major fractures and others. Hospitals specializing in rehabilitation medicine and treatment developed from early models such as the Institute of Physical Medicine and Rehabilitation in New York. There are slightly over 500 rehabilitation hospitals and units throughout the country. They are licensed by the states where they are located and accredited by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities. They also qualify under the Medicare Act as hospitals. There are over 600 outpatient facilities offering some level of rehabilitation services.

The primary function of such facilities is to provide diagnosis and treatment of patients for specified medical conditions both surgical and nonsurgical. The characteristics of freestanding hospitals and rehabilitation units differ little from those of

acute care hospitals except their services are focused on fewer treatment areas. The average length of stay is longer because the objective is restoration of impaired functions which generally follow serious disease or injury. Once a patient is released, many require outpatient and home care services. Some disabled people require continuing institutionalization when home and community care are inadequate.

While the emotional benefit of personal independence may not be measured in dollars, psychological, physical and financial independence can. Recent studies of rehabilitation patients who are medically and vocationally rehabilitated show that for every federal dollar invested the person's earnings increase $10 per hour. Cost studies of stroke rehabilitation also show considerable return on the investment in services. A person who is not rehabilitated costs $92,736 in 1988 dollars more to support than a rehabilitated patient living at home. The average cost for a stroke rehabilitation program is $8,000-$11,500 in 1988 dollars. This results in average savings of $81,250 to $84,740, again in 1988 dollars.

In view of the problems of coverage and payment of rehabilitation services, NARF recommends the following to the committee pertaining to HR 5070, the U.S. Health Act of 1986:

A. COVERAGE

Any final proposal from the committee should recognize and cover rehabilitation and the complete spectrum of the patient's rehabilitation and long term care needs. Catastrophic costs are a continuing fact for the rehabilitation patient, the family and others, particularly those with long term disabilities. The challenge is real and solutions must be realistic. Any policy definitely should have catastrophic health insurance as an addition to or replacement for existing benefits, not as a trade-off for or limitation on other benefits which may further burden a majority while benefiting only a few. HR 5070 does this.

B. POPULATIONS

Any final recommendation from the committee should cover all populations including the poor, working poor, unemployed, employed, and Medicare and Medicaid beneficiaries. HR 5070 does this.

C. CONTINUUM OF CARE SETTINGS

Any final recommendations should recognize that services are delivered in alternate settings reflecting the continuum of rehabilitation care and should be covered for payment. These include rehabilitation units of general hospitals, freestanding medical rehabilitation units, hospital outpatient departments, comprehensive outpatient rehabilitation facilities, rehabilitation agencies, skilled nursing facilities and the home. Delivery of services at or while at home as opposed to continued institutionalized care should be emphasized, except when not medically advisable. The final measure should clearly state that services delivered at any of these sites are covered and that these sites are covered providers.

D. SERVICES

Coverage of services offered under Part A and B of Medicare is a starting point for a basic package of rehabilitation services. We are concerned that the Medicaid categorically need package of benefits does not adequately address all needed rehabilitation services. In addition it should provide for the long term care needs of rehabilitation patients by expanding services such as unlimited home health, outpatient rehabilitation, respite, adult day, home health aide and psychosocial rehabilitation services.

E. FINANCIAL THRESHOLD

Any proposal for catastrophic health insurance should include a deductible amount as a percentage of income over a period or as a minimum annual expenditure. HR 5970 proposes a maximum annual out of pocket expenditure of $1,500 for basic health care and long term care.

F. FINANCING

HR 5970 relies upon HMOs for the delivery of services. Given rehabilitation facilities' history with HMOs to date, we find this distrubing for a number of reasons. First for the non Medicare population federally qualified HMOs must provide only two months of rehabilitation services. As noted in the story above and in reports from our members, HMOs either do not provide this services or provide limited rehabilitation services, not comprehensive programs through experienced providers. To date similar problems have occured with Medicare beneficiaries. HMOs

are not well educated about the benefits of rehabilitation both in terms of long term cost savings, lowering over all admissions and returning people to their maximum functional capacity.

We recommend the bill be amended to assure that HMOs if used as the focal point for the delivery:

- o provide comprehensive rehabilitation services both short and long term
- o use existing inpatient and outpatient providers
- o be subject to quality assurance reviews to assure an adequate number and level of services are being provided.

We are prepared to work with the committee as it grapples with these difficult issues.

PREPARED STATEMENT OF JOYCE V. ROMERO, SECRETARY, KANSAS DEPARTMENT ON AGING

We can only estimate the numbers. The 1984 Current Population Survey of the U.S. Bureau of the Census, estimated there are 35 million uninsured Americans. In a 1986 report, the National Council on the Aging estimated there are 40 million persons in the United States who lack health insurance coverage. The U.S. Senate Special Committee on Aging reported in 1985 that there are 3 million people age 55 to 64 who are without insurance; probably at least 10 percent of the total uninsured population.

It is this sub-group, the older population, which concerns the Kansas Department on Aging. In a 1979-1980 study conducted for the Department ("Needs Assessment Survey of Non-Institutionalized Older Kansans"), the total percentage of persons in the sample (n=2,501), all age 60 and over, who did not have any form of insurance was 4 percent. However, 11 percent of the respondents aged 60 to 64 did not have private health insurance or Medicaid, and of course were not covered by Medicare. This group is most at risk. For both the 65 to 74 and the 75 and over age groups, only 2 percent were without insurance.

For older persons without insurance, whether they are uninsured in the work force, widowed, divorced, or have retired early, it can be a long and expensive wait before reaching age 65 when Medicare is available (at which time they are also eligible, if they can afford it, to purchase a Medigap policy). There is a great probability that if uninsured, a chronic illness could impoverish the elderly. According to a recently released study by the U.S. House Select Committee on Aging, two-thirds of individuals and one-third of couples aged 66 and older will spend themselves into poverty within 13 weeks if stricken by a chronic illness that requires long-term care.

Currently not one group insurance policy exists for older adults who are not yet 65 years of age. People who need insurance but are not yet eligible for Medicare had better be prepared to pay extremely high premiums. For example, two years ago Marie Herbel of Wichita, Kansas was paying $77 per month for her group insurance policy. When she retired her individual premium increased to $234 per month. She was not yet 65 so she was not eligible for Medicare and she could not get a group policy because none were offered.

If someone is unemployed or perhaps works only part-time and does not have insurance or has been left uninsured through widowhood or divorce, they most likely will not be able to afford private insurance. They just have to hope they will be able to "get-along."

The U.S. Public Health Service conducted a four state survey of rural physicians this year in Kansas, Missouri, Iowa and Nebraska. A clear majority, 70 percent, of the physicians reported a decrease in their patients' abilities to pay for care. Additionally, 59 percent reported their patients waited to seek treatment until their health problems were advanced. Rather than practice preventive health care, the patients were hoping their conditions would improve so they would not have to see a doctor; obviously this was not the case.

These are indicators of an uninsured or minimally insured population. While the survey did not report the age breakout of the physicians' patients, you can be sure that a significant number were over age 60. Besides the fact that the four states all have a large elderly population*, it is also known that the elderly visit a physician more than twice as often as the younger population.

Something must be done to address this problem. Too many Kansans, too many Americans, do not seek medical care because they can not afford to, and many others wait too long to obtain care because of the expense, at which time their conditions may be chronic. Forcing people to rely on Medicaid is not the best way to solve the medical indigent problem. The uninsured are our newest class of "have-nots"; a class we could help.

The Kansas Department on Aging urges the U.S. House Select Committee on Aging to act on this issue on behalf of those persons who are without insurance protection.

JVR:SW:mj
9/15/86

* Note: In 1984 the percentage of elderly in the four mid-west states: Kansas = 13.3%; Missouri = 13.6%; Iowa = 14.1%; and Nebraska = 13.4%.

CancerCare, Inc.
AND THE NATIONAL CANCER FOUNDATION, INC.

WILLIAM C. PLUNDER
Chairman, Public Affairs Committee

WILLIAM WEINSTOCK
Vice Chairman, Public Affairs Committee

August 4, 1986

To: Honorable Edward R. Roybal, Chairman
Select Committee on Aging
U.S. House of Representatives

Re: H.R. 5070 - The US Health Program Act

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DONALD E. CARRINO
Executive Director

Since we are unable to attend the hearing on H.R. 5070, we are writing to offer some comments on your proposal.

Cancer Care, Inc. is a voluntary social service agency which, for over 41 years has offered comprehensive social services to cancer patients and their families. We have offices in New York City, Long Island, and New Jersey, and have recently opened a new office in Los Angeles. We are completely dependent upon contributions from the public and foundations. During our '84-'85 fiscal year we served 9,984 patients, and the call on our services has increased markedly.

Cancer Care's services include individual and group counseling, help with planning for the care of the patient, and some financial assistance to eligible families to help them meet the costs of home care plans and transportation to and from treatments. We are also utilizing a special foundation grant in 3 boroughs of New York City to assist certain medically indigent patients with payments for cancer therapies. During our '84-'85 years, we disbursed $864,000. We anticipate the total for our '85-'86 year will be $1,010,000 and are planning for even more disbursements next year, $1,077,000.

In addition to our direct services to clients, Cancer Care maintains a vigorous public affairs program and responds to legislative and policy issues relevant to the needs of cancer patients and the catastrophically ill, in general.

Cancer Care has many times in the past advocated for a national health insurance program that would provide adequate coverage for catastrophic illness, especially coverage for appropriate and sufficient home care and other out-patient needs. What we mean by this is home care that is not predicated on the current Medicare acute care model which allows for only part-time and intermittent home health aide services if the patient requires a skilled service.

You can have as serious an illness as cancer and need help at home without necessarily requiring a skilled service. Most of the elderly patients we are helping financially are not eligible for Medicare's home health services. Others are receiving some, but we are enabling them to get more home care coverage because their condition and situation warrant it.

We are, therefore, gratified that the intent of H.R.5070 is to move away from Medicare's current emphasis on the acute care model for the delivery of home health services. We would have preferred, however, to have this more clearly spelled out in the legislation, and we hope that this will be rectified.

We are pleased that the proposal includes coverage for intermediate care facilites in addition to skilled nursing facilities, remedial and rehabilitative care, prescribed drugs, dentures, prosthetic devices and eyeglasses. However, we hope that you will see fit also to include coverage for social work counseling since such counseling helps patients and their families cope more effectively with the stresses and strains of illness.

We wish to commend you, Representative Roybal, for presenting this proposal which, after so many years, reintroduces the concept of a national health insurance program which would provide a one-tier system of medical care for all Americans. We hope that this proposal will be given the serious consideration which it deserves.